



**Written Contribution to the Human Rights Committee
Draft General Comment 36 on Article 6 (Right to Life) – Call for Comments**

The Center for Reproductive Rights, Amnesty International, Human Rights Watch, the International Commission of Jurists and Ipas are grateful for the opportunity to make a written contribution to the Human Rights Committee (the Committee) ahead of its second reading of the draft general comment on article 6 of the International Covenant on Civil and Political Rights (the Covenant) on the right to life.

The current draft enables a more comprehensive examination of the right to life. We commend the Committee for the enhanced clarity on the measures States parties must take to respect, protect and fulfill women’s and girls’ right to life. The current version of the general comment reflects the Committee’s recognition of the specific right to life violations that women and girls face, which are often related to their childbearing capacities and gender stereotypes.

Critically, the draft as currently formulated also rightly acknowledges that the right to life concerns the entitlement of individuals to enjoy a life with dignity.¹ In addition, the current draft accurately affirms that the right to life, in turn, encompasses the exercise of other rights that affect an individual’s ability to enjoy one’s right to life with dignity,² such as the right to the highest attainable standard of health. Moreover, we welcome the removal of references to the application of Covenant rights before birth, consistent with the Committee’s own jurisprudence, the Covenant’s own *travaux préparatoires*³ and in alignment with relevant international, regional and national practice.⁴

In the present document, we highlight key areas in which this Committee could further support States parties to respect, protect and fulfill women’s and girls’ right to life. Gendered threats to this right are inextricably intertwined with women’s and girls’ lower socioeconomic status globally, as well as their unique health risks, which may be compounded by marginalization on other grounds. In light of these considerations, this submission focuses on three specific areas that merit further attention:

1. Recognition of the rights to non-discrimination, equality before the law and equal protection of the law, specifically in relation to gender and sex, as fundamental components of the right to life (paragraph 9);
2. Liberalization of abortion laws to ensure women’s and girls’ right to life by eliminating preventable maternal mortality and morbidity (paragraph 9); and
3. Ensuring access to a comprehensive range of quality sexual and reproductive health services in order to prevent maternal mortality and morbidity and enable women and girls to enjoy the right to life (paragraph 30).

I. The right to life is interdependent on, and indivisible from, the right to non-discrimination, as well as the right to equality before the law and equal protection of the law, as gender-based discrimination detrimentally affects women's and girls' right to life.

As the Committee has aptly acknowledged in this draft general comment, the right to life, as well as its enjoyment with dignity, is inherently connected to the exercise of other Covenant rights. Restrictions on women's and girls' access to sexual and reproductive health services, including safe abortion, not only implicate the right to life, but also the rights to non-discrimination (articles 2 and 3), privacy (article 17), freedom from torture, cruel inhumane and degrading treatment (article 7), and the right to equality before the law and equal protection of the law without discrimination (article 26).⁵ Noting the interdependence of these rights is critical to ensuring women's and girls' right to life, especially with regard to their access to sexual and reproductive health services.

In this context, States parties must ensure the right to non-discrimination as a fundamental part of realizing the right to life, particularly for women and girls, as well as other marginalized groups. Non-discrimination and equality are core principles of human rights law. In discussing equality between women and men, this Committee has noted that States parties must take "all necessary steps" to enable every person to enjoy the Covenant's rights, asserting that a country must not only adopt measures of protection, but must also take "positive measures in all areas so as to achieve the effective and equal empowerment of women."⁶ It has also stated that interference with women's access to reproductive health care, including failure to ensure that women do not have "to undergo life-threatening clandestine abortions," violates their right to non-discrimination, as well as their right to life.⁷ Concurrences in the cases of *Mellet v. Ireland* and *Whelan v. Ireland* have also underscored the need to address gender-based discrimination intrinsic to abortion restrictions.⁸ For example, in *Mellet*, one of the concurrences found that "[t]he right to sex and gender equality and non-discrimination obligates States to ensure that State regulations, including with respect to access to health services, accommodate the fundamental biological differences between men and women in reproduction and do not directly or indirectly discriminate on the basis of sex."⁹

This stance and reasoning is also supported by the Committee on the Elimination of Discrimination against Women (CEDAW), which has explicitly recognized that, "[m]easures to eliminate discrimination against women are considered to be inappropriate if a health-care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."¹⁰

Intersectional discrimination, meaning that individuals experience multiple, simultaneous and compounding forms of discrimination, can impede women's and girls' access to health care and their right to life. For example, in the case of *Alyne da Silva Pimentel v. Brazil*, the CEDAW addressed the relationship between women's rights to life, health and non-discrimination regarding the preventable maternal death of a poor, Afro-Brazilian woman due to the denial of adequate maternal health care. The CEDAW determined that "the lack of appropriate maternal health services in the state party that clearly fails to meet the specific, distinctive health needs and interests of women" violates the right to health and non-discrimination, as protected under the CEDAW Convention.¹¹ It also noted that the plaintiff "suffered from multiple discrimination" and that "discrimination against women based on sex and gender is inextricably linked to other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, cast and sexual orientation and gender identity."¹² The CEDAW found that such discrimination contributed to her death.¹³ Moreover, the Committee on Economic, Social and Cultural Rights (CESCR), in its general comment on the right to sexual and reproductive health, has acknowledged the pernicious nature of intersectional discrimination, identifying groups such as poor women, persons with disabilities, migrants, adolescents and people living with HIV and AIDS as more likely to experience multiple discrimination.¹⁴ It has called on States parties to take measures to specifically address the "exacerbated impact" of such discrimination.¹⁵

Moreover, the Working Group on Discrimination against Women in Law and Practice noted that countries violate women's rights when they "neglect women's health needs, fail to make gender-sensitive health interventions, deprive women of autonomous decision-making capacity and criminalize or deny them access to health services that only women require," remarking that these situations can result not only in cruel, inhuman or degrading treatment, but also violations of the right to life.¹⁶

In the context of its second reading of paragraph 9 of the draft general comment, as currently formulated, the Committee has the opportunity to clarify that States parties' obligations to realize women's and girls' right to life are contingent upon the rights to non-discrimination, as well as equality before the law and equal protection of the law. This includes addressing gender-based discrimination and intersectional discrimination, compounded by marginalization on other grounds, that manifest themselves as restrictions on essential health services that only women need.

II. States parties must liberalize restrictive abortion legislation to realize women's right to life.

According to the World Health Organization (WHO), there are over 25 million unsafe abortions performed each year,¹⁷ which not only results in deaths but also life-altering disabilities.¹⁸ Almost all of the deaths and instances of morbidity occur in countries with restrictive laws on abortion.¹⁹ Access to safe abortion needs to be guaranteed by all States parties in order to protect women's and girls' right to life. This Committee has recognized that unsafe abortion undermines women's right to life and has urged States parties to amend their abortion laws to ensure that women do not have to resort to illegal and unsafe abortions.²⁰

- a. International law recognizes broader abortion-related human rights standards, not only to advance gender equality and women's autonomy, but also to eliminate preventable maternal mortality and morbidity.

Increasing legal access to abortion not only enhances women's and girls' sexual and reproductive health, but also reduces maternal mortality and morbidity. Evidence demonstrates that where abortion is legal on broad grounds, there is a lower rate of unsafe abortions as well as a lower maternal mortality rate.²¹ Creating enabling environments around abortion access can also reduce maternal morbidity.²² Moreover, women seek abortions for various reasons, many of which do not fall into the current human rights standard on abortion access,²³ which requires legalization in cases of threat to the woman's life or health, in cases of rape or incest and in cases of fatal fetal impairment.²⁴

Regarding state practice, more than 30 countries in the last 20 years have liberalized their abortions laws, allowing for expanded access to legal abortion.²⁵ This includes over a dozen countries in Africa, seven in Asia and six in Latin America and the Caribbean. Several of these countries adopted permissive laws that allow abortion on request or on broad socioeconomic grounds.²⁶

Evidence-based and gender-sensitive interpretations of international human rights law and standards have enabled human rights mechanisms to take into account the abovementioned considerations and to urge states to take action on abortion in a more comprehensive manner. Other treaty bodies general comments/recommendations have not listed the grounds for abortion, with the most recent relevant general comments/recommendations choosing to elaborate a broad formulation consistent with the rights of women and girls to non-discrimination and individual autonomy. In 2016, the CESCR, in its general comment 22 on the right to sexual and reproductive health called for States parties to "liberalize restrictive abortion laws" and "guarantee access to safe abortion services and quality post-abortion care."²⁷ The Committee on the Rights of the Child (CRC), in its general comment on the right to health, recognized that a continuum of care is essential during pregnancy, including "safe abortion services and post-abortion care", and

recommended that States parties ensure access to such services.²⁸ Furthermore, in its general recommendation on women in conflict, the CEDAW called on States parties to “ensure that sexual and reproductive health care includes access to... safe abortion services.”²⁹ Notably, the CESCR contextualized increased access to abortion, as well as other sexual and reproductive health services, within States parties’ obligation to “respect the right of women to make autonomous decisions” about their health.³⁰

The Special Procedures of the UN Human Rights Council have also advocated for a more comprehensive human rights standard for abortion. The UN Working Group on Discrimination against Women recommended that states should “recognize women’s right to be free from unwanted pregnancies”, and “allow women to terminate a pregnancy on request during the first trimester” or later “in cases of risk to the life or health of the woman, rape, incest and fatal impairment of the fetus.”³¹ Moreover, the Special Rapporteurs on Health, Torture and Violence against Women, as well as the Chair-Rapporteur of the Working Group on Discrimination against Women, issued a joint statement calling on states to provide abortion services on request during the first trimester, with later terminations permissible “in cases of risk to [women’s] life or health, including mental health, rape, incest and fatal impairment of the fetus.”³² They noted that restrictive laws and policies on abortion not only contravene human rights law, but also “negate [women’s] autonomy in decision-making about their own bodies.”³³

This evidence attests to the fact that narrow exceptions to abortion bans are inadequate in eliminating preventable maternal mortality and morbidity due to unsafe abortions. Thus, they fail to protect women’s and girls’ right to life. In the context of its second reading of the draft general comment, by further elaborating the content of paragraph 9 to align it with the abovementioned standards for abortion access, this Committee would build on its own and other treaty body jurisprudence, provide the appropriate latitude for States parties to take affirmative steps to strengthen protections on women’s and girls’ right to life, as well as allow for the continued affirmation of reproductive rights under international human rights law in a manner consistent with the Covenant.

- b. States parties must decriminalize abortion to ensure that women and girls can realize their right to life.

International law has recognized that criminalization of abortion leads to high rates of clandestine abortions, which, in turn, increases maternal mortality and morbidity. This Committee has repeatedly expressed concern about the relationship between restrictive abortion laws, unsafe abortions and maternal mortality.³⁴ For example, in its review of Argentina in July 2016, this Committee urged the country to “consider decriminalizing abortion” so that women and girls are not obliged to resort to clandestine abortions.³⁵

Criminalization of abortion contributes to stigmatization and creates a chilling effect on service access and provision. Criminal penalties cause service providers to be more reluctant in providing abortions, even in situations where it is legal.³⁶ Moreover, criminalization presents barriers not only to abortion, but also to other essential reproductive health services that women and girls need. For instance, criminalization of abortion results in women being reported, prosecuted and imprisoned for having miscarriages, creating a chilling effect on women from seeking care.³⁷

Other treaty bodies have addressed this issue. While the CRC has urged States parties to decriminalize abortion for several years,³⁸ it recently further elaborated on this by calling for the decriminalization of abortion in “all circumstances.”³⁹ Furthermore, in its general comment 20 on the implementation of the rights of the child during adolescence, the CRC urged States parties “to decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services.”⁴⁰ The CEDAW has also said that laws that criminalize medical procedures only needed by women are barriers to health care and “when possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.”⁴¹ The CEDAW explicitly linked this recommendation to reducing maternal

mortality. Furthermore, in its general recommendation 35 on gender-based violence against women, the CEDAW recognized criminalization of abortion, as well as denial or delay of safe abortion and post-abortion care, not only as violations of women's sexual and reproductive health and rights, but also as "forms of gender-based violence that...may amount to torture or cruel, inhuman or degrading treatment."⁴² It also called for states to decriminalize abortion.⁴³

Regarding medical providers, this Committee has noted, in its general comment on the equality of men and women, that States parties should take measures to eliminate and protect against interference related to women's reproductive functions. It specifically referenced the imposition of a legal duty on doctors or other health personnel to report cases of women who have undergone abortion as an example of such an interference, acknowledging that such an imposition jeopardizes women's right to life, as well as their right to be free from torture or other cruel, inhuman or degrading treatment.⁴⁴ Furthermore, this Committee has explicitly recommended that a state should "avoid penalizing medical professionals in the conduct of their professional duties" in relation to abortion and the right to life.⁴⁵ The CEDAW has also noted that it is critical for physician-patient confidentiality to be maintained, especially within the context of laws that require medical personnel to report women who have had abortions.⁴⁶ Moreover, the Special Rapporteur on the right to health has noted the importance of decriminalizing abortion, including the decriminalization of the abetment of abortion.⁴⁷

Criminalizing abortion creates a chilling effect that undermines access to health services and results in an increase of preventable maternal deaths and morbidity. By calling for the decriminalization of voluntary termination of pregnancy in paragraph 9, this general comment would provide critical guidance to States parties on compliance with article 6 and the realization of women's and girls' right to life.

c. Barriers to abortion services must be removed to safeguard women's and girls' right to life.

This Committee has recognized that barriers to abortion services threaten women's right to life and has urged States parties to remove them.⁴⁸ It has called on them to remove and address all such obstacles, including third party authorization, conscientious objection and undue delays caused, for example, by prolonged review periods of decisions on abortion, which may drive women and girls to resort to clandestine, unsafe abortions.⁴⁹ Thus, States parties not only have an obligation to refrain from introducing barriers to access to safe and legal abortion, but also to actively eliminate existing barriers.

Other treaty bodies have also called on States parties to refrain from introducing barriers to abortion services or to eliminate them. As the CEDAW noted in its general recommendation no. 24, the "obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals", and "States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women."⁵⁰ The CRC has also affirmed the importance of minors having access to health services without parental consent.⁵¹ Furthermore, it has stated generally that "there should be no barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization."⁵² Additionally, the CRC has spoken out against biased counselling, noting it is key for "health care professionals [to] provide medically accurate and non-stigmatizing information on abortion."⁵³ The Committee against Torture (CAT) has also called for States parties to eliminate requirements of judicial consent for abortion, including in the cases of rape.⁵⁴ Moreover, the CESCR has reaffirmed the importance of removing barriers interfering with women's access to sexual and reproductive health services, goods and information in its general comment on the right to sexual and reproductive health.⁵⁵

From the medical perspective, the WHO has recognized that barriers deter women from seeking safe abortions and thus jeopardize their lives. The WHO has therefore called for the removal of such barriers.⁵⁶

It has also called for expanded access to safe abortion care, including access to affordable services, as well as task shifting service provision so that more healthcare providers and facilities that can lawfully perform abortions.⁵⁷ This is particularly important in rural areas where there is a dearth of qualified physicians.

In elaborating paragraph 9 of general comment no. 36, the Committee has the opportunity to call on States parties to remove all barriers to safe and legal abortion in order to protect women's and girls' right to life.

III. States need to take effective steps to ensure the enjoyment of women's and girls' right to life, which includes access to a continuum of sexual and reproductive health services.

Ensuring access to a comprehensive range of quality sexual and reproductive health services is critical to realizing women's and girls' right to life. Women and girls face unique risks to their lives due to discrimination, inequalities and stereotypes related to their gender and sex, which can be compounded by other marginalized status. One third of health issues for women aged 15-44 are related to sexual and reproductive health.⁵⁸ Moreover, over 200 million women of reproductive age who want to avoid pregnancy do not have access to modern contraceptive methods.⁵⁹ This Committee has recognized the centrality of sexual and reproductive health to women's right to life, and has urged states to ensure access to reproductive health services for all women and adolescents, including access to emergency obstetrics care and emergency contraceptives.⁶⁰ It has explicitly noted the link between reducing maternal mortality and ensuring that women have access to reproductive health services.⁶¹ Essential sexual and reproductive health services aim to protect women's and girls' right to life, which, as set out above, encompasses their entitlement to enjoy a life with dignity,⁶² and is premised on the central importance of personal autonomy to human dignity. Protecting women's and girls' right to life thus requires States parties to provide pre- and post-natal care, skilled birth attendants, emergency obstetrics services, as well as access to contraceptives and information.⁶³

Essential health services must be delivered through a human rights based approach, ensuring non-discrimination, informed consent and confidentiality. The WHO, along with 11 other United Nations entities, have recognized that discrimination in health care settings “serves as a barrier to accessing health services, affects the quality of health services provided, and reinforces exclusions from society for both individuals and groups.”⁶⁴ Such discrimination also prevents people from seeking the health care services that they need.⁶⁵ The CAT has also expressed concern regarding the ill-treatment of women in maternity hospitals, particularly the practice of detaining women who are unable to pay their bills post-delivery. It has called for an end to this practice of forcible detention.⁶⁶ In addition to non-discrimination and fair treatment, health services must also emphasize full, free and informed consent, as well as confidentiality. International law has recognized that forced medical treatments are human rights violations, with some forms of coercion constituting violence against women.⁶⁷ The right to privacy and confidentiality are key human rights in ensuring access to health services.⁶⁸ In fact, this Committee has recognized the relationship between this right and access to health services in acknowledging that a woman's decision to pursue a voluntary termination of pregnancy falls within the scope of article 17, the right to privacy.⁶⁹ If services are delivered in a discriminatory manner, without informed consent and without ensuring privacy, women and girls will be less likely to access them to get the care that they need, thus fundamentally impeding women's and girls' health, and potentially leading to circumstances that jeopardize their right to life.

By recognizing that women require access to a broad spectrum of quality sexual and reproductive health services provided in a non-discriminatory manner, with informed consent and confidentiality in paragraph 30, general comment no. 36 would provide States parties with important guidance on the implementation of, and compliance with, their article 6 obligations.

IV. Conclusion

We applaud the Human Rights Committee's longstanding commitment to women's sexual and reproductive health and rights and its recognition that such rights are fundamentally intertwined with the right to life. This Committee's previous recommendations and jurisprudence have emphasized the need to enact, implement and monitor effective laws and policies focused on respecting, protecting and fulfilling these rights. In light of its history, as well as the current status of international law, we respectfully request that the Committee consider including the following considerations in its second reading of the general comment on the right to life:

- Emphasizing the importance of non-discrimination, as well as equality before the law and equal protection of the law, especially in relation to gender- and sex-based discrimination, as well as intersectional discrimination, in outlining States parties' obligations to realize the right to life (paragraph 9);
- Reaffirming States parties' obligations to guarantee access to safe and legal abortion in order to protect women's and girls' right to life, encompassing a call for immediate decriminalization and removal of barriers to abortion (paragraph 9); and
- Realizing women's enjoyment of the right to life by ensuring access to the full range of sexual and reproductive health services, provided in a non-discriminatory manner that respects informed consent and confidentiality (paragraph 30).

In addition to the core organizations that formally submitted this comment, the following organizations and individuals endorse the contents of this submission:

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- Asia Pacific Forum on Women, Law and Development (APWLD)
- Association for Women's Rights in Development (AWID)
- ASTRA Network, Central and Eastern European Network for Sexual and Reproductive Health and Rights
- British Pregnancy Advisory Service (BPAS)
- Cambridge Reproductive Health Consultants, USA
- Catholics for Choice
- Católicas pelo Direito de Decidir – Brasil
- Center for Education, Counselling and Research (CESI), Croatia
- Centro de Derechos de Mujeres (CDM) Honduras
- Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos (PROMSEX), Peru
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- DEMUS, Peru
- Development Alternatives with Women for a New Era (DAWN)
- ECUARUNARI (Confederation of Kichwa Peoples of Ecuador)
- Equipo Latinoamericano de Justicia y Género (ELA)
- European Humanist Federation
- Family Planning New Zealand
- Federación de Planificación Familiar Estatal (FPFE), Spain
- Federation for Women and Family Planning, Poland
- FIAN International
- Forum for Women, Law and Development (FWLD), Nepal
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- Global Health Justice Partnership, Yale Law School**
- Global Justice Center
- Grupo Curumim, Brazil
- Grupo de Información en Reproducción Elegida, AC, Gire Mexico
- Hungarian Civil Liberties Union (HCLU - TASZ)
- Instituto de Liderazgo Simone de Beauvoir (ILSB - Mexico)
- International Campaign for Women's Right to Safe Abortion
- International Humanist and Ethical Union (IHEU)
- International Planned Parenthood Federation (IPPF)
- International Women's Health Coalition (IWHC)
- Irish Family Planning Association (IFPA)
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- Planned Parenthood Global (PPFA)
- Population Services International (PSI)
- Population, Reproductive, and Sexual Health Section - American Public Health Association, USA
- Realizing Sexual and Reproductive Justice Alliance (RESURJ)
- Rede de Desenvolvimento Humano (REDEH), Brazil
- Rutgers, Netherlands
- Sexual Rights Initiative (SRI)
- Sexuality Policy Watch, Rio de Janeiro, Brazil

- SIA Legal Team, USA
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- Women's Global Network for Reproductive Rights
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* Endorsing in their individual capacity

** This endorsement reflects the view of the Global Health Justice Partnership only, and not that of Yale Law School.

¹ See Human Rights Committee, *Draft General Comment on Article 6 of the International Covenant on Civil and Political Rights – Rights to Life*, para. 3 as currently formulated and para. 30 (advanced unedited version) [hereinafter Human Rights Committee, *Draft General Comment on Article 6*].

² See *id.*, para. 30, as well as paras. 3, 10 and 65 as currently formulated.

³ The negotiating history of several human rights instruments, including the *travaux préparatoires* of this Covenant, suggest that article 6, as well as human rights more generally, vest at birth. See, U.N. GAOR Annex, 12th Sess., Agenda Item 33, at 113, U.N. Doc. A/C.3/L.654 (1957); U.N. GAOR, 12th Sess., Agenda Item 33, at 199(q), U.N. Doc. A/3764 (1957). The proposed and rejected text read, “the right to life is inherent in the human person from the moment of conception.” See also U.N. GAOR 3rd Comm., 99th mtg., paras 110-124, U.N. Doc. A/PV/99 (1948); Question of a Convention on the Rights of the Child: Rep. of the Working Group, U.N. Comm’n on Human Rights, 36th Sess., U.N. Doc. E/CN.4/L.1542 (1980). See also Rep. of the Working Group on a Draft Convention on the Rights of the Child, U.N. Comm’n on Human Rights, 45th Sess., at 11, U.N. Doc. E/CN.4/1989/48 (1989).

⁴ This approach is reinforced by regional instruments, as well as national jurisprudence. The drafters of the African Charter explicitly rejected language extending the right to life prior to birth - compare Frans Viljoen, *The African Charter on Human and People’s Rights/The Travaux Préparatoires in the Light of Subsequent Practice*, 25 HUM. RTS. L.J. 313, 314 (2004) (noting that the drafters of the African Charter relied largely on the American Convention on Human Rights), with Draft African Charter on Human and Peoples’ Rights, art. 17, O.A.U. Doc. CAB/LEG/67/1 (1979) (adopting the language of art. 4(1) of the American Convention on Human Rights, but replacing “moment of conception” with the “moment of his birth”). The European Court of Human Rights declined to find that a fetus enjoys the right to life under the European Convention – see *A, B and C v. Ireland*, No. 25579/05 Eur. Ct. H. R., para. 227 (2010); *Open Door and Dublin Well Woman v. Ireland*, No. 14235/88 Eur. Ct. H.R., para. 68 (1992). Even though the American Convention protects the right to life from “the moment of conception,” the Inter-American Court of Human Rights determined that embryos do not constitute persons and cannot be afforded an absolute right to life – see *Artavia Murillo et al. (“In Vitro Fertilization”) v. Costa Rica*, Preliminary Objections, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R., series C, No. 257, paras. 264, 273 (Nov. 28, 2012). For national cases, please refer to *Lakshmi Dhikta v. Nepal*, Supreme Court of Nepal, WO-0757, 2067 (2009) (“Neither does science nor the law recognize the existence of a human being until birth. Our constitution does not anywhere speak of the rights of a child that has not been born.”); see also *Roe v. Wade*, 410 U.S. 113 (1973) (“[T]he law has been reluctant to endorse any theory that life, as we recognize it, begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth...[i]n short, the unborn have never been recognized in the law as persons in the whole sense.”)

⁵ 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.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*, Committee on the Elimination of Discrimination against Women (CEDAW Committee), Commc’n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011); Human Rights Committee, *Concluding Observations: Ireland*, para. 9, U.N. Doc. CCPR/C/IRL/CO/4 (2014).

⁶ Human Rights Committee, *General Comment No. 28: Article 3 (The Equality of Rights between Men and Women)*, para. 3, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2000) [hereinafter Human Rights Committee, *Gen. Comment No. 28*].

⁷ *Id.* at 10-11, 20.

⁸ *Mellet v. Ireland*, Human Rights Committee, Commc’n No. 2324/2013, Appendix II, para. 7, U.N. Doc. CCPR/C/116/D/2324/2013 (2016) (opinion of Cleveland, S., concurring,); see also *Mellet v. Ireland*, Human Rights

Committee, Commc'n No. 2324/2013, Appendix I (opinion of Ben Achour, Y., concurring), Appendix IV (opinion of Rodríguez Rescia, V., de Frouville, O., Salvioli, S., concurring), U.N. Doc. CCPR/C/116/D/2324/2013 (2016); Whelan v. Ireland, Human Rights Committee, Commc'n No. 2425/2014, Annex II (opinion of Cleveland, S., concurring), U.N. Doc. CCPR/C/119/D/2425/2014 (2017); *see also* Whelan v. Ireland, Human Rights Committee, Commc'n No. 2425/2014, Annex I (opinion of Ben Achour, Y., concurring), Annex III (opinion of de Frouville, O., concurring), U.N. Doc. CCPR/C/119/D/2425/2014 (2017).

⁹ Mellet v. Ireland, Human Rights Committee, Commc'n No. 2324/2013, Appendix II, para. 7, U.N. Doc. CCPR/C/116/D/2324/2013 (2016) (opinion of Cleveland, S., concurring); *see also* Whelan v. Ireland, Human Rights Committee, Commc'n No. 2425/2014, Annex II (opinion of Cleveland, S., concurring), U.N. Doc. CCPR/C/119/D/2425/2014 (2017).

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

¹¹ Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 7.6, U.N. Doc. CEDAW/C/49/D/17/2008 (2011) [hereinafter Alyne v. Brazil].

¹² *Id.*, para. 7.7.

¹³ *Id.*, para. 7.7.

¹⁴ Committee on Economic, Social and Cultural Rights (CESCR Committee), *General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, para. 30, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter CESCR Committee, *Gen. Comment No. 22*].

¹⁵ *Id.*, para. 30.

¹⁶ UN Working Group on the issue of discrimination against women in law and practice, *Rep. of the Working Group on the issue of discrimination against women in law and practice*, Human Rights Council (32nd Sess.), para. 14, U.N. Doc. A/HRC/32/44 (2016) [hereinafter UN Working Group on DAW 2016 Report].

¹⁷ Ganatra, B., et al., *Global, regional, and subregional classification of abortions by safety, 2010-14: estimates from a Bayesian hierarchical model*, THE LANCET, at 1 (Sept. 27, 2017), available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)31794-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/fulltext) [hereinafter Ganatra, B. et al., *Global, regional, and subregional classifications of abortions by safety*].

¹⁸ WORLD HEALTH ORGANIZATION (WHO), *Safe abortion: technical and policy guidance for health systems* (2nd ed. 2012), available at www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en [hereinafter WHO, 2012 Safe Abortion Guidance].

¹⁹ *See* Ganatra, B. et al., *Global, regional, and subregional classifications of abortions by safety*, *supra* note 17, at 1; WHO, 2012 Safe Abortion Guidance, *supra* note 18, at 87.

²⁰ *See, e.g.*, Human Rights Committee, *Concluding Observations: Jamaica*, para. 14, U.N. Doc. CCPR/C/JAM/CO/3 (2011) (urging the state to “amend its abortion laws to help women avoid unwanted pregnancies and not to resort to illegal abortions that could put their lives at risk. The State party should take concrete measures in this regard, including a review of its laws in line with the Covenant.”); Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003); Human Rights Committee, *Concluding Observations: Djibouti*, para. 9, U.N. Doc. CCPR/C/DJI/CO/1 (2013); Human Rights Committee, *Concluding Observations: Ireland*, para. 13, U.N. Doc. CCPR/C/IRL/CO/3 (2008). *See also* Human Rights Committee, *Gen. Comment No. 28*, *supra* note 6, para. 10.

²¹ Berer, M., *National laws and unsafe abortion: the parameters of change*, 12(24 Suppl) REPROD HEALTH MATTERS 1-8 (Nov 2004).

²² WHO, 2012 Safe Abortion Guidance, *supra* note 18.

²³ Chae, S., Desai, S., Crowell, M., Sedgh, G., *Reasons Women Have Induced Abortions: A Synthesis of Findings from 14 Countries*, 96 CONTRACEPTION 233-241 (2017).

²⁴ *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); Committee Against Torture (CAT Committee), *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); Human Rights Committee, *Concluding Observations: Sierra Leone*, para. 14, U.N. Doc. CCPR/C/SLE/CO/1 (2014); Committee on the Rights of the Child (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); CESCR 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).

²⁵ CENTER FOR REPRODUCTIVE RIGHTS, ABORTION WORLDWIDE: 20 YEARS OF REFORM at 9 (2014), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/20Years_Reform_Report.pdf [hereinafter CENTER FOR REPRODUCTIVE RIGHTS, ABORTION WORLDWIDE].

²⁶ See *id.*, at 14, 18, 21, 22, 24, 29, 30 (liberalizations in Albania, Cambodia, Fiji, Guyana, Luxembourg, Nepal, Portugal, South Africa, Spain, Switzerland, Uruguay); see also *Legal reform in Mozambique widens access to safe abortion care*, IPAS (Dec. 23, 2014), <http://www.ipas.org/en/News/2014/December/Legal-reform-in-Mozambique-widens-access-to-safe-abortion-care.aspx>.

²⁷ CESCR Committee, *Gen. Comment No. 22*, *supra* note 14, para 28.

²⁸ CRC Committee, *General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24)*, paras. 54, 70, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter CRC Committee, *Gen. Comment No. 15*].

²⁹ CEDAW Committee, *General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations*, para. 52(c), U.N. Doc. CEDAW/C/GC/30 (2013). See also CEDAW Committee, *Concluding Observations: New Zealand*, para. 35(a), U.N. Doc. CEDAW/C/NZL/CO/7 (2012) (urging a state permitting abortion where pregnancy poses a risk to the woman's physical or mental health and in instances of rape or incest to amend its abortion law "to ensure women's autonomy to choose."); *Sierra Leone*, para. 32, U.N. Doc. CEDAW/C/SLE/CO/6 (2014).

³⁰ CESCR Committee, *Gen. Comment No. 22*, *supra* note 14, para. 28.

³¹ UN Working Group on DAW 2016 Report, *supra* note 16, para. 107(b) and (c).

³² Press Release, "Unsafe abortion is still killing tens of thousands of women around the world" UN rights experts warn (Sept. 28, 2016), available at <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20600&LangID=E>.

³³ *Id.*

³⁴ Human Rights Committee, *Concluding Observations: Chile*, para. 15, U.N. Doc. CCPR/C/CHL/CO/6 (2014); *Costa Rica*, para. 17, U.N. Doc. CCPR/C/CRI/CO/6 (2016) (referring to cases of rape, incest, and fatal fetal impairment); *Malawi*, para. 9, U.N. Doc. CCPR/C/MWI/CO/1/Add.1 (2014); *Sierra Leone*, para. 14, U.N. Doc. CCPR/C/SLE/CO/1 (2014); *Malta*, para. 13, U.N. Doc. CCPR/C/MLT/CO/2 (2014); *Sri Lanka*, para. 10, U.N. Doc. CCPR/C/LKA/CO/5 (2014); *Paraguay*, para. 13, U.N. Doc. [CCPR/C/PRY/CO/3 \(2013\)](#); *Peru*, para. 14, U.N. Doc. [CCPR/C/PER/CO/5 \(2013\)](#); *Guatemala*, para. 20, U.N. Doc. [CCPR/C/GTM/CO/3 \(2012\)](#); *Mexico*, para. 10, U.N. Doc. [CCPR/C/MEX/CO/5 \(2010\)](#); *El Salvador*, para. 10, U.N. Doc. CCPR/C/SLV/CO/6 (2010); *Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010); *Jamaica*, para. 14, U.N. Doc. CCPR/C/JAM/CO/3 (2011); *Dominican Republic*, para. 15, U.N. Doc. CCPR/C/DOM/CO/5 (2012); *Nicaragua*, para. 13, U.N. Doc. [CCPR/C/NIC/CO/3 \(2008\)](#); *Djibouti*, para. 9, U.N. Doc. CCPR/C/DJI/CO/1 (2013).

³⁵ Human Rights Committee, *Concluding Observations: Argentina*, para. 12, U.N. Doc. CCPR/C/ARG/CO/5 (2016).

³⁶ *Tysiac v. Poland*, No. 5410/03, Eur. Ct. H. R., para. 116 (2007).

³⁷ UN Working Group on DAW 2016 Report, *supra* note 16, para. 79; see also CEDAW Committee, *Concluding Observations: El Salvador*, para. 36(a), U.N. Doc. CEDAW/C/SLV/CO/8-9 (2017); CENTER FOR REPRODUCTIVE RIGHTS, MARGINALIZED, PERSECUTED AND IMPRISONED: THE EFFECTS OF EL SALVADOR'S TOTAL CRIMINALIZATION OF ABORTION (2014), available at <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/El-Salvador-CriminalizationOfAbortion-Report.pdf>; Erika Guevara-Rosas, *El Salvador and 'Las 17'*, NYTIMES (Mar. 2, 2015), <https://www.nytimes.com/2015/03/03/opinion/el-salvador-and-las-17.html?mcubz=0>.

³⁸ CRC Committee, *Concluding Observations: Gambia*, para. 63(b), U.N. Doc. CRC/C/GAM/CO/2-3 (2015); *Dominican Republic*, para. 52(d), U.N. Doc. CRC/C/DOM/CO/3-5 (2015); *Morocco*, para. 57(b), U.N. Doc. CRC/C/MAR/CO/3-4 (2014).

³⁹ CRC Committee, *Concluding Observations: Peru*, para. 56(b), U.N. Doc. CRC/C/PER/CO/4-5 (2016); *Kenya*, para. 50(b), U.N. Doc. CRC/C/KEN/CO/3-5 (2016); *Haiti*, para. 51(c), U.N. Doc. CRC/C/HTI/CO/2-3 (2016); *Senegal*, para. 54(d), U.N. Doc. CRC/C/SEN/CO/3-5 (2016); *Ireland*, para. 58(a), U.N. Doc. CRC/C/IRL/CO/3-4 (2016).

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- ⁴⁰ CRC Committee, *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence*, para. 60, U.N. Doc. CRC/C/GC/20 (2016) [hereinafter CRC Committee, *Gen. Comment No. 20*].
- ⁴¹ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 10, para. 31(c).
- ⁴² CEDAW Committee, *General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, para. 18, U.N. Doc. CEDAW/C/GC/35 (2017) [hereinafter CEDAW Committee, *Gen. Recommendation No. 35*].
- ⁴³ *Id.*, para. 31(a).
- ⁴⁴ Human Rights Committee, *Gen. Comment No. 28*, *supra* note 6, para. 20.
- ⁴⁵ Human Rights Committee, *Concluding Observations: Nicaragua*, para. 13, U.N. Doc. [CCPR/C/NIC/CO/3 \(2008\)](#).
- ⁴⁶ CEDAW Committee, *Concluding Observations: El Salvador*, para. 37(b), U.N. Doc. CEDAW/C/SLV/CO/8-9 (2017).
- ⁴⁷ 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(h),(i), U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover).
- ⁴⁸ Human Rights Committee, *Concluding Observations: Bolivia*, para. 9(b), U.N. Doc. CCPR/C/BOL/CO/3 (2013); *Zambia*, para. 18, U.N. Doc. CCPR/C/ZMB/CO/3 (2007); *Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000).
- ⁴⁹ Human Rights Committee, *Concluding Observations: Poland*, para. 24(a), U.N. Doc. CCPR/C/POL/CO/7 (2016); *see also* Human Rights Committee, *Concluding Observations: former Yugoslav Republic of Macedonia*, para. 11, U.N. Doc. CCPR/C/MKD/CO/3 (2015); *Spain*, para. 13, U.N. Doc. CCPR/C/ESP/CO/6 (2015); *Italy*, paras. 16, 17, U.N. Doc. CCPR/C/ITA/CO/6 (2017).
- ⁵⁰ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 10, para. 14.
- ⁵¹ CRC Committee, *Gen. Comment No. 15*, *supra* note 28, para. III(a) (“States parties shall strive to ensure that no child is deprived of his or her right of access to such health care services”).
- ⁵² CRC Committee, *Gen. Comment No. 20*, *supra* note 40, para. 60.
- ⁵³ CRC Committee, *Concluding Observations: Slovakia*, para. 41(e), U.N. Doc. CRC/C/SVK/CO/3-5 (2016). *See also* CESCR Committee, *Gen. Comment No. 22*, *supra* note 14, para. 41.
- ⁵⁴ CAT Committee, *Concluding Observations: Bolivia*, para. 23, U.N. Doc. CAT/C/BOL/CO/2 (2013).
- ⁵⁵ CESCR Committee, *Gen. Comment No. 22*, *supra* note 14, para. 28.
- ⁵⁶ These barriers include lack of access to information; requiring third-party authorization; failing to guarantee confidentiality and privacy; and allowing conscientious objection without referrals on the part of health-care providers and facilities. *See* WHO, 2012 Safe Abortion Guidance, *supra* note 18, at 95-97.
- ⁵⁷ Task shifting involves re-distribution of tasks among the health force work team. In the case of access to abortion, it means allowing health care providers (beyond physicians) to perform abortions, thus increasing its availability and accessibility. *See* WHO, 2012 Safe Abortion Guidance, *supra* note 18, at 95-97. *See also* WHO, Task Shifting: Global Recommendations and Guidelines, *available at* http://www.who.int/workforcealliance/knowledge/resources/taskshifting_guidelines/en/ (for further guidance on task shifting).
- ⁵⁸ Press Release, World Health Organization, Promoting health through the life-course (Mar. 2015), <http://www.who.int/life-course/news/commentaries/2015-intl-womens-day/en/>.
- ⁵⁹ WHO, Factsheet: Family planning/contraception (Jul. 2017), *available at* <http://www.who.int/mediacentre/factsheets/fs351/en/>.
- ⁶⁰ Human Rights Committee, *Concluding Observations: Cameroon*, para. 13, U.N. Doc. CCPR/C/CMR/CO/4 (2010) (urging the state to “step up its efforts to reduce maternal mortality, including by ensuring that women have access to reproductive health services.”). *See also*, Human Rights Committee, *Concluding Observations: Chile*, para. 15, U.N. Doc. CCPR/C/CHL/CO/6 (2014); *Costa Rica*, para. 17, U.N. Doc. CCPR/C/CRI/CO/6 (2016); *Malawi*, para. 9, U.N. Doc. CCPR/C/MWI/CO/1/Add.1 (2014); *Sierra Leone*, para. 14, U.N. Doc. CCPR/C/SLE/CO/1 (2014); *Malta*, para. 13, U.N. Doc. CCPR/C/MLT/CO/2 (2014); *Sri Lanka*, para. 10, U.N. Doc. CCPR/C/LKA/CO/5 (2014); *Paraguay*, para. 13, U.N. Doc. [CCPR/C/PRY/CO/3 \(2013\)](#); *Peru*, para. 14, U.N. Doc. [CCPR/C/PER/CO/5 \(2013\)](#); *Guatemala*, para. 20, U.N. Doc. [CCPR/C/GTM/CO/3 \(2012\)](#); *Jamaica*, para. 14, U.N. Doc. CCPR/C/JAM/CO/3 (2011); *Dominican Republic*, para. 15, U.N. Doc. CCPR/C/DOM/CO/5 (2012). *See also* Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003) (on emergency obstetrics care); *Peru*, para. 14, U.N. Doc. [CCPR/C/PER/CO/5 \(2013\)](#) (on emergency contraceptives).

⁶¹ Human Rights Committee, *Concluding Observations: Cameroon*, para. 13, U.N. Doc. CCPR/C/CMR/CO/4 (2010) (urging the state to “step up its efforts to reduce maternal mortality, including by ensuring that women have access to reproductive health services.”). *See also*, Human Rights Committee, *Concluding Observations: Chile*, para. 15, U.N. Doc. CCPR/C/CHL/CO/6 (2014); *Costa Rica*, paras. 17-18, U.N. Doc. CCPR/C/CRI/CO/6 (2016); *Malawi*, para. 9, U.N. Doc. CCPR/C/MWI/CO/1/Add.1 (2014); *Sierra Leone*, para. 14, U.N. Doc. CCPR/C/SLE/CO/1 (2014); *Malta*, para. 13, U.N. Doc. CCPR/C/MLT/CO/2 (2014); *Sri Lanka*, para. 10, U.N. Doc. CCPR/C/LKA/CO/5 (2014); *Paraguay*, para. 13, U.N. Doc. [CCPR/C/PRY/CO/3 \(2013\)](#); *Peru*, para. 14, U.N. Doc. [CCPR/C/PER/CO/5 \(2013\)](#); *Guatemala*, para. 20, U.N. Doc. [CCPR/C/GTM/CO/3 \(2012\)](#); *Jamaica*, para. 14, U.N. Doc. CCPR/C/JAM/CO/3 (2011); *Dominican Republic*, para. 15, U.N. Doc. CCPR/C/DOM/CO/5 (2012). *See also* Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003) (on emergency obstetrics care); *Peru*, para. 14, U.N. Doc. [CCPR/C/PER/CO/5 \(2013\)](#) (on emergency contraceptives).

⁶² *See* Human Rights Committee, *Draft General Comment on Article 6*, *supra* note 1, para. 3 as currently formulated, and para. 30.

⁶³ *See* WHO, *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities* (2016), available at <http://apps.who.int/iris/bitstream/10665/249155/1/9789241511216-eng.pdf?ua=1> (for maternal care services); WHO, *Priority Lifesaving Medicines for Women and Children* (2012), available at http://apps.who.int/iris/bitstream/10665/75154/1/WHO_EMP_MAR_2012.1_eng.pdf?ua=1 (for contraceptives); United Nations Population Fund (UNFPA), *Sexual & reproductive health*, <http://www.unfpa.org/sexual-reproductive-health> (for access to SRH information).

⁶⁴ UNAIDS, UNHCR, UNICEF, WFP, UNDP, UNFPA, UN Women, ILO, UNCESCO, WHO, OHCHR, IOM – Joint United Nations statement on ending discrimination in health care settings (June 2017), available at http://www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf.

⁶⁵ *Id.*

⁶⁶ CAT Committee, *Concluding Observations: Kenya*, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013).

⁶⁷ CEDAW Committee, *Gen. Recommendation No. 35*, *supra* note 42, para. 18. *See also* CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 10, para. 22; CRC Committee, *General Comment No. 13 (2011) The right of the child to freedom from all forms of violence*, para. 23(a), U.N. Doc. CRC/C/GC/13 (2011).

⁶⁸ OHCHR, Harvard FXB, Partnership for Maternal, Newborn & Child Health (PMNCH), UNFPA, WHO, *Summary Reflection Guide on a Human Rights-Based Approach to Health*, at 14 (2015), available at <http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/HealthWorkers.pdf>.

⁶⁹ *Mellet v. Ireland*, Human Rights Committee, Commc’n No. 2324/2013, para. 7.7, U.N. Doc. CCPR/C/116/D/2324/2013 (2016). *See also* *L.M.R. v. Argentina*, Human Rights Committee, Commc’n No. 1608/2007, paras. 9.3, 9.4, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).