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Interpreting International Humanitarian Law to Guarantee Abortion and Other Sexual and Reproductive Health Services in Armed Conflict

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Abstract

The provision of basic sexual and reproductive health services in humanitarian settings, including armed conflict, is extremely limited, causing preventable mortalities and morbidities and violating human rights. Over 50% of all maternal deaths occur in humanitarian and fragile settings. International humanitarian law falls short in guaranteeing access to the full range of sexual and reproductive health information and services for all persons. Guaranteeing access to sexual and reproductive health services under international humanitarian law can increase access to services, improving the health and well-being of civilians in conflict zones. This paper sets forth ways in which international human rights law on sexual and reproductive health and rights should be incorporated into the forthcoming International Committee of the Red Cross Commentary on Geneva Convention IV, regarding the protection of civilians, to ensure services in the context of armed conflict.

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Introduction

In the 1950s and 1960s, the International Committee of the Red Cross (ICRC) published a set of commentaries on the Geneva Conventions, giving practical guidance to support these treaties' implementation. These commentaries are considered a definitive source of interpretation of obligations under the Geneva Conventions. In 2011, the ICRC and a team of experts embarked on an effort to update the commentaries to reflect recent developments in law and practice and, hence, new interpretations of the conventions.[1] Currently, the ICRC has commissioned a Commentary on Geneva Convention IV, which covers the protection of civilians.

It is important to recall that customary international humanitarian law (IHL) provides that "the specific protection, health and assistance needs of women affected by armed conflict must be respected."[2] In order to achieve this and customary IHL's own recognition that it should be viewed in light of the "prominent place of women's rights in human rights law," the forthcoming Commentary on Geneva Convention IV must go further in applying the long-standing international human rights law (IHRL) protections in the area of sexual and reproductive health and rights without discrimination.[3] It is insufficient merely to recognize that the Geneva Conventions are outdated without more robustly tackling the health needs of persons long discriminated against and ignored, as well as the gendered biases that are embedded in IHL.

Updated commentaries on other Geneva Conventions reflect, to some degree, the progressive changes that have taken place in recent decades under domestic law and IHRL and in practice with regard to women and persons of diverse sexual orientation, gender identity and expression, and sex characteristics. However, the history of the subordination of these populations under international law requires continued commitment and vigilance to ensure a contemporary interpretation in IHL that incorporates continued developments in IHRL and domestic law, including in the area of sexual and reproductive health and rights.[4]

This paper begins with a brief overview of the factors that hinder access to sexual and reproductive health (SRH) services in humanitarian settings, including in armed conflict. We then explore how IHL provisions ensuring humane treatment and guaranteeing no adverse distinction should be read consistently with IHRL obligations on the right to be free from torture, cruel, and inhuman and degrading treatment and the right to nondiscrimination, respectively, in the area of sexual and reproductive health and rights. Next, we provide examples of how articles 16 and 27 in Geneva Convention IV, as well as common article 3, could be interpreted to include SRH services more comprehensively. Finally, we argue that the forthcoming commentary should interpret relevant provisions of Geneva Convention IV in line with developments in state practice on laws on abortion.

Background

The United Nations (UN) Office for the Coordination of Humanitarian Affairs has estimated that nearly 300 million people will need humanitarian assistance and protection in 2024, with more people being forcibly displaced now than at any other time since the beginning of this century.[5] Conflict, climate crisis, and economic factors are the main drivers of these emergency situations.[6] UNFPA emphasizes that during conflicts and emergencies, SRH needs are often unmet, with grave consequences.[7] Lack of access to delivery and emergency obstetric care poses life-threatening complications for those who are pregnant.[8] Loss of access to contraceptives exacerbates unintended pregnancy in already perilous conditions.[9] Women and girls continue to remain at increased risk of sexual violence, exploitation, and HIV infection, with all the mental, physical and social consequences.[10] Conflict settings have demonstrated consistently higher maternal mortality rates than non-conflict settings, as well as lower access to reproductive and maternal health services for marginalized populations, including poor, less educated, and rural populations.[11]

International and regional human rights law on torture and on nondiscrimination support more robust considerations of sexual and reproductive health and rights in IHL

Alongside IHL, IHRL applies during armed conflict.[12] Customary IHL recognizes that IHRL instruments, documents, and case law support, strengthen, and clarify analogous principles of IHL.[13]

Two sets of rights and principles where IHRL has been expressly used to clarify IHL—and which are important for ensuring greater access to SRH services—are (1) the right to be free from torture and other ill treatment (as enshrined in IHLR) and the principle of humane treatment (as enshrined in IHL); and (2) the right to nondiscrimination (as enshrined in IHRL) and the principle of no adverse distinction (as enshrined in IHL).

IHRL's right to be free from inhuman and degrading treatment in the area of sexual and reproductive health and rights should be reflected in IHL's obligation of humane treatment

Humane treatment is considered a norm of customary international law from which there can be no derogation.[14] It requires that all non-combatants, including civilians and the sick and wounded, be treated humanely in all circumstances and with respect for their person and honor, without any adverse distinction based on sex or other similar criterion.[15]

Customary IHL notes that "the detailed rules found in international humanitarian law and human rights law give expression to the meaning of 'humane treatment'" and that "this notion develops over time under the influence of changes in society."[16] These "changes in society" are reflected in the ICRC's 2016 and 2020 updated Commentaries on Geneva Conventions I and III, respectively, which note that "sensitivity 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."[17] In the commentaries, the ICRC helpfully references numerous health and sexual and reproductive rights issues—including involuntary sterilization and "gender-based humiliation such as shackling women detainees during childbirth"—as examples of violations of common article 3 that human rights bodies have found to violate IHRL's right to freedom from torture and other ill treatment.[18]

While these examples are important to include, the obligation of humane treatment under IHL should more robustly encompass the range of SRH services that are protected under the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment under IHRL.[19] While it is important not to create a framework of humane treatment that risks being narrow and inflexible, and thus incapable of responding to circumstances that arise in the contemporary world, the 2020 Commentary on Geneva Convention III's article 3 recognizes that some guidance is needed—otherwise, there is too much discretion that could lead to interpretations incompatible with ensuring humane treatment.[20] Providing examples in the forthcoming commentary on Geneva Convention IV that reflect long-standing protections of IHRL on access to SRH services, such as abortion, emergency contraception, and emergency obstetric care, would be critical to closing this gap.[21]

UN treaty bodies and Special Procedures. Over the past two decades, authoritative regional and UN treaty body and Special Procedure mandate holders have articulated the lack or denial of SRH services as violations of the right to be free from torture and cruel, inhuman, and degrading treatment.

The Committee against Torture, which monitors state compliance with the Convention against Torture, recognizes that "the contexts in which females are at risk [of torture or ill treatment and the consequences thereof] include … medical treatment, particularly involving reproductive decisions."[22]

For example, the committee has long found that denying or delaying safe abortion or post-abortion care may amount to torture or cruel, inhuman,

or degrading treatment.[23] It has long expressed concern over complete bans on abortion and other restrictive abortion laws and practices, recognizing that they may constitute violations of articles 2 and 16 of the convention.[24] It has consistently found that the denial or delay of post-abortion care can violate obligations under the convention and has recommended ensuring access to post-abortion care, regardless of the law.[25]

The committee has also recognized how the denial of relevant services for survivors of sexual violence, including emergency contraception and abortion, exposes them to ongoing violations.[26]

Similarly, the Human Rights Committee, which monitors state compliance with the International Covenant on Civil and Political Rights, in the first-ever case on denial of access to abortion in the UN treaty body system and in every single subsequent case thereafter, has found that denial of abortion, regardless of its legal status, constitutes physical and mental suffering amounting to a violation of article 7.[27]

The committee reinforces this interpretation in its General Comment 36 on the right to life.[28]

Most recently, the Committee on the Rights of the Child, which monitors state compliance with the most widely ratified human rights treaty—the Convention on the Rights of the Child—in its first-ever decision related to the denial of abortion to a minor, found a violation of cruel, inhuman, and degrading treatment.[29]

The African, European, and inter-American human rights systems have also considered that the denial or delay of abortion and other SRH services is a violation of the right to be free from torture and other ill treatment under their respective treaties.[30]

The UN Special Rapporteur on torture has noted that "international human rights law increasingly recognizes that abuse and mistreatment of women seeking reproductive health services cause tremendous and lasting physical and emotional suffering," which can constitute cruel and degrading treatment.[31]

In September 2021, seven Special Procedure mandate holders, including the Special Rapporteur on torture, filed an amicus brief with the US Supreme Court in an abortion case that eventually overturned 50 years of abortion protection under the US Constitution. In this brief, they argued that IHRL protects abortion access and that prohibitions on such access breach numerous international human rights, including the right to be free from torture and cruel, inhuman, or degrading treatment, and asked the court to uphold existing constitutional protections on abortion and refuse the retrogression of rights.[32]

IHL's prohibition of adverse distinction should be interpreted consistently with IHRL's right to nondiscrimination

The prohibition of adverse distinction is found throughout the Geneva Conventions.[33] IHL's approach to the prohibition of adverse distinction is similar to IHRL's approach to the prohibition of discrimination.[34] State practice establishes this rule as a norm of customary international law.[35]

The ICRC's 2016 Commentary on Geneva Convention I notes that "sex is traditionally recognized as justifying, and in fact requiring, differential treatment."[36] It recognizes:

> *Grounds for non-adverse distinction could also be found in an awareness of how the social, economic, cultural or political context in a society forms roles or patterns with specific statuses, needs and capacities that differ among men and women of different ages and backgrounds. Taking such considerations into account is no violation of the prohibition of adverse distinction, but rather contributes to the realization of humane treatment of all persons protected under common Article 3.*[37]

This is an important recognition, particularly in the area of sexual and reproductive health and rights, given that many of the challenges concerning the availability and accessibility of SRH information and services exist because of discrimination on grounds of sex, gender, and sexual orientation, as well as related harmful gender stereotypes.

The fact that the IHL principle of no adverse distinction is similar to the human rights principle of nondiscrimination suggests that IHRL should

provide guidance as to how this principle should be interpreted, including in the context of SRH services.[38]

State obligations on nondiscrimination under IHRL require ensuring access to SRH services. Fulfilling the right to nondiscrimination requires ensuring access to sexual and reproductive health care. UN treaty bodies have repeatedly articulated that the failure to provide such services, including contraception and abortion, is a form of discrimination against women.[39] As early as 1999, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) articulated that "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[40]

A year later, the Human Rights Committee also addressed restrictions on access to reproductive health services as forms of discrimination and inequality, including during armed conflict.[41] For over 25 years, these and other human rights bodies have consistently articulated that the lack of access to or the denial of SRH services constitutes discrimination against women, perpetuates harmful gender stereotypes, and violates a range of other human rights.[42] With regard to abortion, human rights treaty bodies have articulated that the denial of access to abortion and restrictive abortion laws can violate the right to nondiscrimination.[43] For example, the CEDAW Committee, in a special inquiry, found that abortion restrictions in Northern Ireland constituted discrimination because they affected only women, were a form of gender-based violence in violation of the convention, and "affront[ed] women's freedom of choice and autonomy, and their right to self-determination."[44]

IHRL also requires states to eliminate multiple and intersectional discrimination, including in the area of sexual and reproductive health and rights.[45]

Discrimination in access to SRH services in armed conflict. IHRL has specifically recognized that the right to nondiscrimination in relation to SRH services applies in armed conflict. The CEDAW Committee notes that during armed conflict or states of emergency, states should not suspend rights protections but rather "adopt strategies and take measures addressed to the particular needs of women."[46] It specifically recommends access to, among other things, sexual and reproductive health and rights information; psychosocial support; family planning services, including emergency contraception; maternal health services, including antenatal care, skilled delivery services, and 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, and other reproductive health complications.[47] It is important to note that the CEDAW Committee's guidance does not condition the provision of safe abortion services to circumstances in which abortion services are legal.

Addressing gender stereotypes in IHL and improving access to SRH services

IHL falls short in protecting access to the full range of SRH information and services for all persons, including survivors of sexual and gender-based violence, despite the fact that IHL expressly recognizes that women face specific needs in armed conflict.[48]

Treatment of women under the Geneva Conventions. The obligation that "women shall be treated with all consideration due to their sex" can be found throughout the Geneva Conventions.[49] The 1960 Commentary on Geneva Convention III sets forth three considerations to be taken into account when applying this provision: women's "weakness," their "honour and modesty," and their role in "pregnancy and child-birth."[50] Although this concept is referring to women prisoners of war, it captures the stereotypes and normative bias against women and persons of diverse sexual orientation, gender identity and expression, and sex characteristics that are reflected throughout the Geneva Conventions. For example, article 16 of Geneva Convention IV covers

treatment of the "wounded and sick" and "other persons who may be in need of immediate medical assistance or care, such as . . . *expectant mothers*," and article 27 sets forth specific protections for women, stressing that "women shall especially be protected against any attack on their honour."[51]

Although there has been progress in expanding the definition of rape in international law, IHL's formulation of rape as an attack against women's honor and its focus on women who are pregnant fails to view women as independent rights holders with the rights to autonomy and bodily integrity.[52] As one scholar notes:

> *Patriarchal societies generally attach a preeminent value to women's chastity and reproductive capacity, seeing women's reproduction as a way of guaranteeing the survival of both community and culture. A woman who is sexually violated, impregnated by enemies, or kidnapped into sexual and domestic enslavement is therefore often regarded as "disgracing family honor, being unclean or contaminated, [or] being a seductress."*[53]

It is widely accepted that international law has established and reinforced harmful stereotyped roles of women as mothers or as pregnant.[54] In fact, 9 out of the 19 provisions in the four Geneva Conventions referring to women refer to them as pregnant or mothers of small children.[55] While resulting protections, including related health care guarantees, are crucial, the root of many barriers to comprehensive sexual and reproductive health care lies in harmful gender stereotypes that see women's primary roles as mother, child bearer, and caregiver and that perpetuate binary norms in the provision of SRH services.[56]

Gender stereotypes

All UN treaty bodies have attempted to address these harmful stereotypes by recognizing them as discriminatory and in need of reform.[57] Article 5 of CEDAW creates express obligations to address harmful stereotypes and their underlying causes.[58] The CEDAW Committee, and other treaty bodies, has recognized the negative impact that harmful stereotypes have on access to SRH services specifically, noting that patriarchal attitudes and stereotypes about women as mothers and caregivers, prejudices about SRH services, and taboos about sexuality outside of marriage all contribute to the lack of access to reproductive health information, goods, and services.[59] In *L.C. v. Peru*, the committee affirmed that restrictions on access to abortion embed a harmful stereotype that "understands the exercise of a woman's reproductive capacity as a duty rather than a right."[60] The Committee against Torture acknowledges that non-conformity with gender stereotypes plays a central role in "the ways that women and girls are subject to or at risk of torture or ill-treatment and the consequences thereof" and "may be subject to violations of the Convention on the basis of their actual or perceived non-conformity with socially determined gender roles."[61] The International Covenant on Civil and Political Rights, under its nondiscrimination and equality provisions, also requires states to address gender stereotyping.[62]

More recent ICRC commentaries shift away from the harmful stereotypes found in the Geneva Conventions and earlier commentaries.[63] For example, the 2020 Commentary on Geneva Convention III, in explaining the meaning and obligations related to article 14(2)'s statement that "women shall be treated with all regard due to their sex," notes that it

> *is not to be understood as implying that women have less resilience, agency or capacity within the armed forces, but rather as an acknowledgement that women have a distinct set of needs and may face particular physical and psychological risks.*[64]

The ICRC commentaries from 2016 and 2020 note social and international legal developments under IHRL on nondiscrimination and equality, citing to the International Covenant on Civil and Political Rights and the Convention on the Elimination of All Forms of Discrimination against Women.[65]

Medical care

The updated Commentaries on Geneva Conventions I and III have also begun articulating better, albeit still limited, recognition of the comprehensive reproductive health care needed in armed

conflict under articles related to medical care.

ICRC Commentaries on Geneva Convention I (article 12, protection and care of the wounded and sick) and Geneva Convention III (article 16, equality of treatment of prisoners) provide for an intersectional and substantive equality approach to the provision of health care.[66] For example, the 2020 Commentary on Geneva Convention III notes, "To ensure equal treatment of women, they must be treated with all due regard to their sex. This means that in terms of medical care, for example, female prisoners may require access to ante- and postnatal care and gynaecological and reproductive health care."[67]

Importantly, the updated commentaries expand protection beyond maternal health care to include "gynecological and reproductive health."[68] They also require that military medical services include a "range of expertise and skills" to care for "both male and female patients."[69] Moreover, they require that parties to a conflict plan and analyze the various types of health care that are needed by considering power structures and their impact, specifically

> *how the roles and patterns formed by the social, economic, cultural or political context and resulting in different statuses, needs and capacities among women and men of different ages and backgrounds could hamper the safe access to care of any one group. This may include a reluctance to seek or receive medical care, possibly owing to discrimination or a stigma of being wounded or sick. Knowledge of how social structures influence the situation should be taken into account in order to ensure that health care is fully accessible to both women and men and minimizes the risks of any group being subject to discrimination, lack of respect, harm or danger before, during or after the care.*[70]

The 2020 Commentary on Geneva Convention III's article 14 specifically recognizes the gender-specific physical, mental, and psychosocial effects of sexual violence against women, including medical complications during pregnancy and stigma.[71] It requires that "the Detaining Power take proactive measures to prevent such incidents from occurring and to ensure that women who are victims of sexual violence have access to appropriate, gender-specific health care."[72]

The widespread use of rape as a weapon of war has also raised issues concerning what types of medical treatment and care must be provided to survivors of rape, in particular whether there is an obligation to provide abortion services under IHL.[73] The Oxford University Press commentary on the Geneva Conventions notes that these instruments "do not prevent the interpretation of the notion of 'medical care' as including abortion."[74] The ICRC commentaries indicate that medical services should be equipped to handle "women's gynaecological and reproductive health issues," without noting limitations.[75]

In addition, the 2020 Commentary on Geneva Convention III's article 30, which concerns medical attention, notes that "an infirmary's lack of medical capacity may not be used as a blanket justification for being unable to address the specific needs of women prisoners."[76] This implies that it is discriminatory to deny women health care that is needed only by them, in line with the Convention on the Elimination of All Forms of Discrimination against Women and other IHRL treaty obligations.[77]

The commentary continues:

> *In all cases, the provision of medical care must comply with the applicable standards of medical ethics … respect for the autonomy and agency of prisoners of war with regard to their voluntary and informed consent—or refusal—to undergo any medical procedure; respect for medical confidentiality … and the prohibition on engaging—actively or passively—in acts that may amount to torture or other cruel, inhuman or degrading treatment or punishment.*[78]

UN agency guidance

The World Health Organization, UNFPA, and the Office of the United Nations High Commissioner for Human Rights have consistently called for stakeholders to address the dire situation regarding the lack of access to SRH services in humanitarian settings, including in armed conflict.[79] For example, they support the implementation of the Minimum Initial Service Package for SRH in crisis situations, which sets forth specific services that should be provided to address the overlooked SRH needs

of affected populations, the absence of which have potentially life-threatening consequences.[80] This package is the most widely applied technical standard for the provision of SRH services in humanitarian settings.[81]

The overwhelming progressive state practice on abortion and World Health Organization guidance

Laws are an important indicator of state practice for consideration in the development of IHL.[82] This section provides an analysis of abortion laws from around the world and of trends in abortion law reform.[83]

There is an overwhelming global trend toward the greater liberalization of abortion laws and increased access to abortion. Fifty-nine countries have liberalized their abortion laws to expand the grounds for legal abortion since the 1994 International Conference on Population and Development, while only four countries have made their laws more restrictive by removing legal grounds for abortion during this time.[84] There is geographic diversity in abortion law reform, notably with nearly half the countries that have liberalized their laws located in Africa.[85] In addition, many countries have also implemented policy and programmatic measures to improve access to safe abortion services.[86]

Liberal reforms are propelled by various factors, including evidence showing that the rate of mortality and morbidity due to unsafe abortion is greatest in countries with restrictive laws and that restrictions do not reduce the number of abortions, only their safety.[87] Moreover, a gender-sensitive understanding of equality and nondiscrimination has been at the center of many of these national developments. Since 2000, at least 20 constitutional courts have issued decisions on the legality of abortion, with six courts upholding laws guaranteeing access to abortion, ten courts deciding that restrictive criminal laws on abortion in whole or in part are unconstitutional, and only four courts deciding that restrictive laws can be or are constitutional.[88]

A few years ago, the European Commission, France, the Netherlands, and the United Kingdom addressed the specific issue of abortion access for rape survivors in statements recognizing that IHL entails an obligation to provide abortion services to rape survivors in armed conflict situations, regardless of national laws.[89]

It is important to note that most countries (about 140 in total) allow abortion in relation to rape and incest. This includes countries whose laws permit abortion by specifically enumerating these grounds; permit abortion on request, without restriction as to reason; permit abortion on broad socioeconomic grounds; and permit abortion on express mental health grounds, in which rape is not an enumerated ground but could be included.[90]

State practice, as illustrated through national-level laws and regulations, however, has for decades been moving away from a grounds-based approach that provides exceptions to criminalization on the grounds of health, life, rape, or severe fetal impairment.[91] Such grounds-based laws have proven ineffective in ensuring access to abortion, even on the grounds permitted under the law.[92] Evidence also shows that grounds-based laws contribute to delays in and denials of abortion, which in turn contributes to unsafe abortion.[93] For these reasons, the World Health Organization recommends, in newly released guidance on abortion, the full decriminalization of abortion and the reform of restrictive laws, including grounds-based laws.[94] Currently, 75 countries allow abortion on request without restriction as to reason, and 13 countries allow it on broad socioeconomic grounds.[95]

Conclusion

The ICRC commentaries are important sources of law that can clarify obligations to protect persons from the effects of armed conflict. By addressing in greater detail the range of SRH services needed by all civilians and the barriers to access that persons face—two areas of IHL that are often overlooked—the forthcoming commentary on Geneva Convention IV can ensure that long-standing and ongoing guidance and obligations under IHRL and regional human rights law find their due place in IHL.

IHL protections on the rule of "no adverse distinction" and in the protection of "humane treatment" should be interpreted consistently with analogous IHRL protections on the right to be free from discrimination and the right to be free from torture and other cruel, inhuman, and degrading treatment or punishment in the context of sexual and reproductive health care. While IHL has long recognized this relationship between the bodies of law, it has to date failed to specifically recognize it in the context of SRH services, despite long-standing IHRL standards in this area.

In addition, while the current commentaries have taken important steps toward addressing some of the gender stereotypes embedded in the Geneva Conventions, the future commentary on Geneva Convention IV can go further by applying this development to the SRH needs of all civilians, not just survivors of violence or pregnant women, and by addressing barriers to health care, including stereotypes.

Abortion care is mentioned only once in the current commentaries—and even then, only in a footnote discussing health care related to sexual violence.[96] While this acknowledgment is an important step, it falls short of what is needed given the dire situation facing persons requiring SRH services in armed conflict and the significant developments under IHRL and new World Health Organization guidelines in this area, which require states to ensure access to emergency contraception and broad access to abortion for all persons, including survivors of rape.[97] Developments in state practice, through progressive law reform on abortion in every region of the world, support this inclusion.

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