Developing the International Law Framework on Maternal Mortality: Ensuring Access to Emergency Obstetric Care and Safe Abortion from Peacetime to Armed Conflict

*Maria Sjöholm**

Maternal mortality is the second leading cause of death among women of reproductive age at a global level. It primarily occurs during delivery or in the immediate post-partum period, due to late detection of complications and a lack of access to emergency obstetrics care and post-natal care. Meanwhile, restrictive laws on sexual and reproductive rights increase the risk of obstetric emergencies, as unsafe abortion is one of the primary causes. Ensuring access to emergency obstetrics care and safe abortion - during peace, armed conflict and in post-conflict situations - is thus vital in preventing maternal mortality. The article evaluates the current framework in public international law as a means of preventing maternal mortality. International human

La mortalité maternelle constitue la deuxième cause de décès chez les femmes en âge de procréer au niveau mondial. Elle survient principalement pendant l'accouchement ou durant la période post-partum subséquente, à cause d'une détection tardive des complications et d'un manque d'accès aux soins obstétriques d'urgence et aux soins postnataux. Entre-temps, les lois qui restreignent les droits sexuels et reproductifs augmentent le risque d'urgences obstétrical es puisque l'avortement à risque en est l'une des principales causes. Il est donc essentiel d'assurer – en temps de paix, en situation de conflit armé et en contexte post-conflit – l'accès aux soins obstétriques d'urgence et à l'avortement sécurisé afin de prévenir la mortalité maternelle. Cet article évalue le

* Maria Sjöholm, LL.M, LL.D, is an associate professor in international law at Örebro University in Sweden. Her research covers a range of areas in international law, mainly with a gender perspective. She was previously a member of the Committee of Feminism and International Law of the International Law Association.

Citation: Maria Sjöholm, "Developing the International Law Framework on Maternal Mortality: Ensuring Access to Emergency Obstetric Care and Safe Abortion from Peacetime to Armed Conflict" (2025) 17:1 McGill JL & Health 96.

Référence: Maria Sjöholm, « Developing the International Law Framework on Maternal Mortality: Ensuring Access to Emergency Obstetric Care and Safe Abortion from Peacetime to Armed Conflict » (2025) 17:1 RD & JL santé McGill 96.

rights law (IHRL), international humanitarian law (IHL) and international criminal law (ICL) to varying degrees address maternal health care, either in the form of rights or as part of prohibitions on certain conduct affecting access to health care.

Several key points are addressed in the article. In order to construct effective measures to prevent maternal mortality through international law, regulation must be formulated and/or interpreted in a gender-sensitive manner. As a first step, this includes considering the causes of maternal mortality as well as exacerbating contextual factors, such as armed conflict, described in chapter two. The third chapter delineates the current scope of protection of maternal health care in IHRL, IHL and ICL, with a focus on obligations to ensure access to emergency obstetrics care and safe abortion. The article assesses whether regulation sufficiently corresponds to the causes of maternal mortality or whether gaps in protection arise within and – to a more limited extent - between these areas of law.

It is concluded that current gaps in all areas emanate from the broad margin of appreciation for states on this matter – in view of resource restraints, practical challenges in humanitarian settings and ideology. This has resulted in the lack of concretisation of these essential services as rights and a lower threshold of obligations. Potential means of resolving gaps and inconsistencies are raised, including applying gender-sensitive evolutive treaty interpretation and clarifying regulation through systemic integration.

cadre actuel du droit international public comme moyen de prévention de la mortalité maternelle. Le droit international des droits de la personne Cet article évalue le cadre actuel du droit international public comme moyen de prévention de la mortalité maternelle. Le droit international des droits de la personne (DIDP), le droit international humanitaire (DIH) et le droit international pénal (DIP) traitent à divers degrés des soins de santé maternelle, soit sous forme de droits, soit sous forme de prohibitions sur certaines conduites affectant l'accès aux soins de santé.

Plusieurs points clés sont abordés dans cet article. Pour élaborer des mesures efficaces de prévention de la mortalité maternelle à travers le droit international, la réglementation doit être formulée et/ou interprétée de manière sensible au genre. Cela suppose, en premier lieu, de prendre en considération les causes de la mortalité maternelle ainsi que les facteurs contextuels aggravants, tels que les conflits armés, décrits au chapitre deux. Le troisième chapitre délimite la portée actuelle de la protection des soins de santé maternelle en DIDP, DIH et DIP, en mettant l'accent sur les obligations d'assurer l'accès aux soins obstétriques d'urgence et à l'avortement sécurisé. L'article évalue si la réglementation répond adéquatement aux causes de la mortalité maternelle ou si des lacunes émergent au sein de ces domaines juridiques – et dans une moindre mesure – entre eux.

Il en ressort que les lacunes actuelles dans l'ensemble de ces domaines découlent de la grande marge de manœuvre laissée aux États en la matière – compte tenu des contraintes budgétaires, des défis pratiques en contexte humanitaire et des considérations idéologiques. Il en résulte un défaut au niveau de la concrétisation de ces services essentiels en tant que droits, ainsi qu'un seuil d'obligations réduit. Divers moyens potentiels pour combler ces lacunes et incohérences sont abordés, incluant l'application d'une interprétation des traités évolutive et sensible au genre et la clarification des règlementations par l'entremise de l'intégration systémique.

I. Introduction

Maternal mortality is the second leading cause of death among women of reproductive age at a global level.[1] This phenomenon involves the death of a woman while pregnant or within 42 days of the termination of pregnancy from causes related to or aggravated by the pregnancy; that is, not from accidental or incidental factors.[2] Maternal mortality primarily occurs during delivery or in the immediate post-partum period, due to late detection of complications and a lack of access to emergency obstetrics and post-natal care.[3] Multiple individual and social factors affect access to care, such as poverty, lack of education, gender stereotyping, and armed conflict. Meanwhile, restrictive laws on sexual and reproductive rights increase the risk of obstetric emergencies, as unsafe abortion is one of the primary causes.[4] Ensuring access to emergency obstetrics care and safe abortion – in all contexts – is thus vital in preventing maternal mortality.

Standards for preventing maternal mortality have mainly been formulated within the field of development cooperation, for example, in relation to the UN Sustainable Development Goals (SDGs).[5] While this ensures global standards and concrete means of evaluating implementation on select issues, the framework consists of norms rather than obligations for states. In contrast, obligations relating to the prevention of maternal mortality arise in several areas of public international law (PIL). While the aim and characteristics of the frameworks differ, the right to maternal health is explicitly regulated and/or affected by rules in international human rights law (IHRL), international humanitarian law (IHL), and international criminal law (ICL).

---

1 World Health Organization, "World Health Statistics 2019: Monitoring Health for the SDGs, Sustainable Development Goal" (2019) at 10.

2 World Health Organization, *International Statistical Classification of Diseases and Related Health Problems,* 5th ed (WHO, 2016) at 183.

3 *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* UN General Assembly, 2013, UN Doc A/68/297 at para 43.

4 *Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights,* UNHRC, 2010, UN Doc A/HRC/14/39 at para 6 [UNHR, *Preventable Maternal Mortality and Morbidity and Human Rights].*

5 *Transforming Our World: The 2030 Agenda for Sustainable Development,* UNGA, 2015, UN Doc A/RES/70/1 at s 3.1 [UNGA Transforming Our World].

While bearing in mind differences in features – which set the boundaries for the right to health – questions arise whether these PIL regimes, jointly, provide an effective framework for preventing maternal mortality from periods of peace to armed conflict.

IHRL provides a comprehensive approach to health care, involving both short-term and long-term interventions. It encompasses a range of services essential for guaranteeing women's health during pregnancy, delivery and the post-natal period. However, under what circumstances and to what extent obligations arise in relation to emergency obstetrics care and abortion upon request warrants clarification. For example, while access to primary health care is a core obligation, the services included are not specified.[6] Meanwhile, rules in IHL and ICL specifically govern the protection of the wounded and sick, medical personnel, units and transports.[7] While the wounded and sick, including maternity cases, must be offered "care," it remains an abstract term. Additionally, though recognition of the socio-economic implications and indirect effects of armed conflict is increasing, maternal health care is regularly addressed as a policy issue, rather than a right, in the context of armed conflicts.[8] The PIL framework is thus characterized by a broad degree of discretion for states in view of resource restraints, practical challenges in humanitarian settings and ideology. However, by further clarifying, harmonizing, and developing the interpretation of provisions affecting maternal health, PIL may act as a more convincing standard setter.

Several key points will be addressed in the article. As a first step, the causes of maternal mortality, as well as exacerbating contextual factors such as armed conflict, are described in Chapter Two. The third chapter delineates the current scope of protection of maternal health care in IHRL, IHL, and ICL, with a focus on obligations to ensure access to emergency obstetrics care and abortion services. The purpose is to assess whether regulation suf-

---

6 *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, CESCR, 22nd Sess, UN Doc E/C.12/2000/4 at para 43 [CESCR*, "General Comment No 14"*].

7 *Ibid* at ss 3.3., 3.4.

8 Christine Chinkin, *Women, Peace and Security and International Law* (Cambridge: Cambridge University Press, 2022) at 30. It should be noted that it is contested whether IHL contains rights for individuals.; See a discussion in Lawrence Hill-Cawthorne, "Rights Under International Humanitarian Law" (2017) 28:4 Eur J Intl L 1187 at 1187.

ficiently corresponds to the causes of maternal mortality or whether gaps in protection arise within and – to a more limited extent – between these areas of law. Potential means of resolving gaps and inconsistencies are raised.

A systemic approach to PIL is proposed as a means in clarifying the content of rules and strengthening cohesion between areas of law, while mindful of distinctions in the regimes. The article also calls for a gender-sensitive interpretation of provisions. The analytical framework for examining the purported neutrality and effectiveness of public international law is the feminist legal method of "asking the woman question." This involves analyzing whether gaps and inconsistencies exist from the perspective of gender equality; that is, areas of non-existing or limited protection for women or regulation with gendered effects.[9] The objective is substantive gender equality. Maternal mortality is a gendered form of harm – affecting women – with gender-specific responses necessary to achieve *de facto* equality.[10] This requires a contextual approach to law, interpreting provisions in relation to actual social conditions, experiences, and contexts.[11] The causes of maternal mortality, including the impact of social conditions, are considered for this reason.

II. Maternal mortality – an overview

A. Causes of maternal mortality

Provisions in PIL relating to the right to health and health care must respond to the conditions that cause maternal mortality. Consideration of the physiological, social, and economic factors undermining maternal health, as well as the types of care needed to prevent maternal mortality, is necessary for the construction of effective obligations. The impact of armed conflict on maternal mortality is also relevant, not only in view of contextual re-

---

9 Katharine Bartlett, "Feminist Legal Methods" (1990) 103:4 Harv L Rev at 837.

10 It should be noted that the term "women" is used in the article but may also involve pregnant individuals who do not identify as women. The reason for using this term is for ease of reading as well as to reflect the concept used in legal sources discussed in the article.

11 *Bartlett*, *supra* note 9 at 836, 849.

quirement, (for instance, in relation to IHL, but in terms of addressing the need for and access to care.

The World Health Organization (WHO) estimates that approximately 15% of women in any given population develop a potentially life-threatening complication during pregnancy or at the time of delivery.[12] Five types of obstetric emergencies account for most maternal deaths: haemorrhage (25%); infection/sepsis (15%); unsafe abortion (13%); pre-eclampsia and eclampsia (12%); and prolonged or obstructed labour (8%).[13] Emergencies often occur as a result of late detection of complications and/or arrival at the health care center and delayed actual care.[14] The vast majority of maternal deaths are thus preventable and within the control of the state, evidenced by the fact that in certain countries maternal mortality has been virtually eliminated.[15]

While primary maternal health care – meaning antenatal, childbirth and postpartum services – is vital to ensuring maternal health, research demonstrates that increased access to, for example, antenatal care has not significantly reduced maternal mortality.[16] It is thus essential to enhance the accessibility and quality of emergency obstetrics care as a means of preventing maternal mortality. Which procedures and technologies are involved in emergency obstetrics care is mainly determined at the domestic level. Nevertheless, PIL increasingly directs states in terms of health care infrastructure through obligations in IHRL and, to a lesser extent, IHL. Commonly, the necessary technologies are described as a package of emergency obstetric care (EmOC).[17] A distinction is made between basic emergency obstetrics care (BEmOC) – with facilities equipped to administer parenteral

---

12 World Health Organization, *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors*, 2nd ed (WHO 2017) at s xi.

13 UNHRC, *Preventable Maternal Mortality and Morbidity and Human Rights*, *supra* note 4 at para 6.

14 Cristina Otero Garcia, *Antenatal Guidelines for Primary Health Care in Crisis Conditions,* (Geneva: International Committee of the Red Cross, 2005) at 10.

15 UNHRC, *Preventable Maternal Mortality and Morbidity and Human Rights*, *supra* note 4 at para 6.

16 Colin Bullough et al, "Review: Current Strategies for the Reduction of Maternal Mortality" (2005) 112:9 British J Obstetrics & Gynecology 1165 at 1183.

17 Lynn Freedman, "Using Human Rights in Maternal Mortality Programs: From Analysis to Strategy" (2001) 75:1 Intl J of Obstetrics & Gynecology at 52.

antibiotics, oxytocic drugs and anticonvulsants, manually remove placenta and retained products as well as assist vaginal delivery-– and comprehensive emergency obstetrics care (CEmOC), which, in addition to such forms of care, can perform cesarean sections and blood transfusions.[18]

Depending on the domestic health care infrastructure, BEmOC may be available in primary health care centers, whereas CEmOC is usually offered at the secondary or tertiary levels of health care, that is, specialised care, often involving referrals.[19] A significant portion of maternal mortality can be prevented through BEmOC alone, by treating many forms of emergency conditions and stabilising situations prior to referrals to specialised care.[20] However, in relation to specific obstetric emergencies, CEmOC is significantly more effective in preventing maternal mortality. For example, BEmOC has a 40% effectiveness rate in treating antepartum haemorrhage, compared to 90% using CEmOC.[21] Certain conditions, such as obstructed labour, generally require access to comprehensive care. Cesarean sections normally account for 5-15 per cent of all births, which is only available through CEmOC.[22] CEmOC is thus a vital means in preventing maternal mortality. However, in contrast to antenatal care, CEmOC involves greater economic resources and is often not accessible in poor or rural areas.[23]

Unsafe abortion-– involving women either self-inducing abortion or seeking abortion from unskilled providers-– is also a preventable cause of maternal mortality. Such can lead to haemorrhage, infection and injury to the genital tract and internal organs, including uterine perforation, which in

---

18 World Health Organization, *Monitoring Emergency Obstetric Care: A Handbook,* (Geneva: WHO*,* 2009) at 7 [WHO*, Monitoring Emergency Obstetric Care]*.

19 *Ibid* at para 10.

20 Suzanne Lee Pollard, Matthews Mathai & Neff Walker, 'Estimating the Impact of Interventions on Cause Specific Maternal Mortality: A Delphi Approach' (2013) 13 BMC Public Health 1 at 4; WHO, *Monitoring Emergency Obstetric Care, supra* note 18 at 11.

21 *Pollard, supra* note 20 at 4.

22 WHO*, Monitoring Emergency Obstetric Care, supra* note 18 at 25.

23 Carine Ronsmans, Sara Holtz & Cynthia Stanton, "Socioeconomic Differentials in Caesarean Rates in Developing Countries: A Retrospective Analysis" (2006) 368:9546 The Lancet 1516 at 1516.

turn may cause infertility.[24] Specialist care is not required to perform abortion unless complications arise.[25] The methods commonly employed in the first trimester are medicated abortion and manual vacuum aspiration.[26] During the first twelve weeks of pregnancy, medical abortion can be managed by the pregnant person outside of health care facilities.[27] Meanwhile, manual vacuum aspiration can be performed in primary health centers by trained mid-level providers without sophisticated equipment or supplies, which is generally the same as needed for BEmOC and gynaecological services.[28] It is thus suggested that abortion services are provided as part of primary health care.[29]

In contrast to the lack of access to EmOC, unsafe abortions are primarily a result of restrictive domestic laws. While there is near-universal access to abortion in cases of a threat to the woman's life, 99 out of 190 states provide access to abortion in cases of rape or inces, or to preserve the mental or physical health of the woman.[30] Just 58 states guarantee abortion upon request.[31] Mortality and morbidity rates are significantly lower in states with

---

24 WHO, *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets,* WHO/RHR/04.8 (Geneva: WHO, 2004) at 15 [WHO, *Reproductive Health Strategy]*.

25 Inter-Agency Working Group on Reproductive Health in Crises, *Inter-Agency Field Manual: On Reproductive Health in Humanitarian Settings* (2018) at 153 [IAWG, *Inter-Agency Field Manual*].

26 For abortion after 14 weeks, dilatation and evacuation are recommended, which require greater resources; See World Health Organization*, Abortion Care Guideline,* (Geneva: WHO, 2022) at 62 [WHO, *Abortion Care Guideline]*.

27 IAWG, *Inter-Agency Field Manual*, *supra* note 25 at 146-147.

28 Therese McGinn & Sara Casey, 'Why Don't Humanitarian Organizations Provide Safe Abortion Services?' (2016) 10:8 Conflict and Health 1 at 2.

29 WHO, *Abortion Care Guideline*, *supra* note 26 at 14.

30 World Health Organization, "Global Abortion Policies Database", online: <abortion-policies.srhr.org> [perma.cc/DNC5-FDDM].

31 *Ibid*; Marge Berer, 'Abortion Law and Policy Around the World' (2017) 19 Health Hum Rights 13 at 17.

few restrictions on access to abortion,[32] and changes in domestic laws on abortion correlate with incidents of maternal mortality.[33]

At a broader level, socio-economic constraints and gender stereotyping are part of the root causes of maternal mortality. This includes poverty, malnutrition, and gender-based violence.[34] Health and health services "exist in political space," informed by social and cultural contexts.[35] Gender norms in certain environments foster early marriages and pregnancy, high levels of sexual violence, and a lack of access to contraception.[36] Between 4% and 20% of women experience violence during pregnancy, which may lead to miscarriage, premature labour, or low birth weight.[37] Women's lack of access to nutrition, clean water, sanitation, and education also increases risks of preventable maternal mortality and morbidity.[38] For example, high rates of illiteracy reduce the use of contraception, prenatal care, and birth spacing.[39] With limited education and information, women may also be unaware of obstetric emergency signals, causing delay in seeking care.[40] The three-delay model, meaning the delay of individuals in seeking, accessing,

---

[32] World Health Organization, "Safe Abortion: Technical & Policy Guidance for Health Systems" online: <apps.who.int> [https://perma.cc/3978-CK4S] [WHO, *Safe Abortion Guidance*].

[33] McGinn & Casey, *supra* note 28 at 4.

[34] *Resolution 15/17: Preventable Maternal Mortality and Morbidity and Human Rights: Follow-Up to Council Resolution 11/8,* UNHRC, 20th Sess, UN Doc A/HRC/RES/15/17 (2010) GA Res 15/17 at para 7.

[35] Freedman, *supra* note 17 at 52.

[36] *Technical guidance on the application of a human rights-based approach to the implementation policies and programmes to reduce preventable maternal morbidity and mortality,* UNHRC, 2012, UN Doc A/HRC/21/22 at para 59 [UNHRC, 'Technical Guidance'].

[37] WHO, *Reproductive Health Strategy*, *supra* note 24 at 16.

[38] UNHR, *Preventable Maternal Mortality and Morbidity and Human Rights, supra* note 4 at para 29.

[39] *Ibid* at para 30. See also Margaret Kruk et al, "Health Care Financing and Utilization of Maternal Health Services in Developing Countries" (2007) 22:5 Health Policy and Planning 303 at 306.

[40] UNHRC, 'Technical Guidance', *supra* note 36 at para 59.

or receiving care, is frequently used to address such sociological and practical impediments to maternal health.[41]

While a global concern, maternal mortality is particularly prevalent in certain regions, which is linked to root causes such as poverty. Sub-Saharan Africa has the highest rates where gender intersects with ethnicity, class, and age in enhancing vulnerability.[42] More than 50% of women deliver their children without the attendance of a skilled health care worker,[43] and 97% of unsafe abortions occur in this region.[44] Maternal mortality as a result of unsafe abortion is also significantly higher in sub-Saharan Africa, with three times the global average.[45] Although other health indicators generally have improved in the global south, maternal mortality rates remain consistent, indicating a lack of prioritization.[46]

B. Armed conflict as an exacerbating factor

Although direct causality is complex, statistics indicate a link between armed conflict and increased maternal mortality.[47] The causes are multiple and involve both the direct and indirect effects of hostilities. In broad terms, armed conflict heightens the *need* for maternal health care while reducing access to and the quality of care. Contemporary armed conflicts are frequently non-international in nature, characterized by protracted, low-level insecurity and violence, involving the targeting of civilians. This includes the use of sexual violence as a tactic of war, which often persists after the

---

41 *Ibid* at para 56.

42 Freedman, *supra* note 17 at 54; Kruk, *supra* note 39 at 304.

43 WHO, *Reproductive Health Strategy*, *supra* note 24 at 11.

44 IAWG, *Inter-Agency Field Manual*, *supra* note 25 at 48.

45 WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008* (Geneva: WHO, 2011) at 22.

46 Kruk, *supra* note 39 at 304.

47 Bernadette O'Hare & David Southall, "First Do No Harm: The Impact of Recent Armed Conflict on Maternal and Child Health in Sub-Saharan Africa" (2007) 100:12 J of the Royal Society of Medicine 564 at 564.

cessation of conflicts.[48] Sexual violence may result in physical harm such as unwanted pregnancy, sexually transmitted diseases (STDs), chronic pelvic pain, as well as vesicovaginal and rectal fistulas.[49] Reduced access to reproductive health care and education - including knowledge of family planning and birth control - also increases the risk of unwanted pregnancy.[50] Furthermore, armed conflict has an impact on the health of the foetus and the mother. Prenatal stress has a detrimental effect on foetal development and childbirth through increased levels of maternal cortisol.[51] Certain sources demonstrate a heightened risk of miscarriage, stillbirth, and prematurity.[52] There also appears to be a correlation between conflict,and preeclampsia.[53] It is thus suggested that pregnant women in such contexts undergo additional ultrasound scanning where appropriate, to monitor foetal growth.[54]

Meanwhile, circumstances such as armed conflict and natural disasters undermine *access* to maternal health care. Women's mobility and freedom of movement are generally restricted in times of conflict.[55] Logistics such as the continuity of the delivery of medical supplies and referrals between primary and specialized health care facilities - including transfers to emer-

---

48 UNSC, 2000, UN Doc S/RES.1325 4213th Mtg at para 10–11; UNSC, 2008, UN Doc S/RES.1820 5916th Mtg at paras 1, 10–11 [UNSC Res 1820].

49 *General recommendation No 30 on women in conflict prevention, conflict and post-conflict situations*, UN CEDAW, 2010, UN Doc CEDAW/C/GC/30 at para 37 [CEDAW, "General Recommendation No 30"]; WHO, "Understanding and addressing violence against women: Health consequences'' (29 November 2012) at 2, online (pdf): <who.int/publications/i/item/WHO-RHR-12.35> [perma.cc/XV9C-CJLB]. .

50 Henrik Urdal & Chi Primus Che, "War and Gender Inequalities in Health: The Impact of Armed Conflict on Fertility and Maternal Mortality" (2013) 39:4 Intl Interactions 489 at 495 [Urdal & Primus Che].

51 James Keasley, Jessica Blickwedel & Siobhan Quenby, "Adverse Effects of Exposure to Armed Conflict on Pregnancy: A Systematic Review" (2017) 2:4 BMJ Global Health 1 at 2 [Keasley, Blickwedel & Quenby].

52 *Ibid* at 1.

53 Claire S Traylor et al, "Effects of Psychological Stress on Adverse Pregnancy Outcomes and Nonpharmacologic Approaches for Reduction: An Expert Review'" (2020) 2:4 American Journal of Obstetrics & Gynecology MFM 1 at 2.

54 Keasley, Blickwedel & Quenby, *supra* note 51 at 1.

55 CEDAW, "General Recommendation No 30", *supra* note 49 at para 50.

gency obstetric care - are frequently disrupted.[56] Health care facilities are also increasingly subject to violent attacks, dubbed a "weaponisation of health care."[57] This includes the targeting of hospitals, patients, and staff. The intentional bombing of maternity hospitals has, for example, been part of the warfare in Ukraine.[58] Refusals to authorize access for humanitarian aid are also common and increasingly part of deliberate strategies to target civilians.[59] International aid organizations have scaled down their assistance in response.[60] These targeted attacks cause both immediate and long-term harm, affecting the general access to health care.

Re-directed government expenditures and shrinking revenues negatively impact civilian infrastructures, such as health care.[61] Health care services may already be fragile predating the conflict as the majority of armed conflicts transpire in states with societal disarray.[62] For example, armed conflict in Africa is a significant cause of poverty, through decreased tax revenue and increased spending on defence.[63] Vulnerable individuals suffer when

---

56 Enrico Pavignani et al, "Making Sense of Apparent Chaos: Health-Care Provision in Six Country Case Studies" (2013) 95:889 Intl Rev Red Cross 41 at 49–50, 54 [Pavignani et al]; CEDAW, "General Recommendation No 30", *supra* note 49 at para 50.

57 See e.g. Independent International Commission of Inquiry on the Syrian Arab Republic, *Report on human rights abuses and international humanitarian law violations in the Syrian Arab Republic, 21 July 2016- 28 February 2017*, UNHRC, 2017, UN Doc A/HRC/34/CRP.3 at para 15; Fouad M Fouad et al, "Health Workers and the Weaponisation of Health Care in Syria: A Preliminary Inquiry for The Lancet–American University of Beirut Commission on Syria" (2017) 390:10111 The Lancet 2516 at 2516.

58 "Ukraine War: Three Dead as Maternity Hospital Hit by Russian Air Strike", *BBC News* (10 March 2022), online: <bbc.com/news/world-europe-60675599> [perma.cc/8Q3U-G5LD].

59 Christa Rottensteiner, "The Denial of Humanitarian Assistance as a Crime under International Law" (1999) 81:835 Intl Rev Red Cross 555 at 556.

60 Fiona Terry, "Violence Against Health Care: Insights from Afghanistan, Somalia, and the Democratic Republic of the Congo" (2013) 95:889 Intl Rev Red Cross 23 at 34.

61 Urdal & Primus Che, *supra* note 50 at 492.

62 Pavignani et al, *supra* note 55 at 42.

63 Xiangming Fang et al, "IMF Working Paper: The Economic Consequences of

infrastructure lapses. According to the United Nations Committee on the Elimination of Discrimination against Women (the CEDAW Committee), women and girls endure the most of the socio-economic crises because of armed conflict.[64] This affects both preventive care, such as antenatal check-ups, as well as emergency obstetrics care. Furthermore, although sexual and reproductive health services including antenatal care are increasingly available in humanitarian settings through international aid, the same cannot be said for emergency obstetrics care and access to safe abortion services.[65] The lack of abortion services in such settings is mainly ideological, evident in restrictive funding policies, with donor states often privileging other forms of health care.[66]

It should be noted that situations of peace, instability, armed conflict, and post-conflict are rarely linear, but frequently characterized by cessations of and return to conflicts in cycles that may continue during long periods of time.[67] Volatile circumstances, while not reaching the level of an armed conflict, may cause major internal displacement and refugee flows.[68] During flight, settlement and return within conflict-affected areas, women are vulnerable to a range of human rights violations, including sexual violence.[69] The adverse effect on health care in volatile contexts not constituting an armed conflict was apparent in Syria. Attacks on patients, health care workers, and facilities were widespread in the period prior to reaching the thresh-

---

Conflict in Sub-Saharan Africa" (2020) International Monetary Fund, Working Paper No 2020/221 at 4, online: <imf.org> [perma.cc/36SC-WJKW].

64 CEDAW, "General Recommendation No 30", *supra* note 49 at paras 48–50.

65 Sara Casey et al, "Progress and Gaps in Reproductive Health Services in Three Humanitarian Settings: Mixed Methods Case Studies" (2015) 9: Supp 1 S3 Conflict and Health 1 at 5, 9.

66 For example, humanitarian aid provided by the US is subject to a 'no abortion clause', which requires that the aid is not used for abortion services. See Akila Radhakrishnan, Elena Sarver & Grant Shubin, "Protecting Safe Abortion in Humanitarian Settings: Overcoming Legal and Policy Barriers" (2017) 25:51 Reproductive Health Matters 40 at 40. See also Therese McGinn & Sara E Casey, "Why don't Humanitarian Organizations provide Safe Abortion Services?" (2016) 10:8 Conflict and Health 1 at 3.

67 CEDAW, "General Recommendation No 30", *supra* note 49 at para 4.

68 *Ibid* at para 5.

69 *Ibid* at para 53.

old of a non-international armed conflict (NIAC). This created a climate of fear among citizens and led to a covert network of makeshift clinics.[70]

Additionally, the collapse of health care infrastructure frequently continues post-conflict and the health consequences of, for example, sexual violence during conflict may remain. For instance, vaginal fistula is a frequent problem in post-conflict Liberia, related to the two civil wars in 1989 and31999.[71] Vaginal fistula is generally caused by prolonged labour in childbirth or sexual violence, affecting women's health in the long-term.[72] In light of the continuum of maternal mortality, a holistic approach to maternal health is necessary. This includes strengthening the convergence of regulations on this matter in IHRL, IHL, and ICL.

III. Addressing maternal health care in international law

A. Public international law as a (gendered) system

Given the causes of maternal mortality, prevention measures include both immediate health interventions and long-term social transformations. This requires an equitable distribution of health care facilities offering BEmOC, CEmOC and safe abortion, a system of rapid delivery of necessary medical supplies and equipment, swift referral systems, and qualified personnel. Provisions on these aspects are found in IHRL, IHL, and ICL, to varying degrees. Meanwhile, long-term measures involve the overall strengthening of gender equality and a broader range of socio-economic rights, which is mainly regulated in IHRL.

As discussed later, certain gaps in terms of effective prevention of maternal mortality appear within these areas of law. This includes the non-regulation of specific services and lac-lustrr obligations. Reasons include the structural limits of PIL but also its gendered nature. The categoriza-

---

70 Katherine Footer & Leonard Rubenstein, "A Human Rights Approach to Health Care in Conflict" (2013) 95:889 Intl Rev Red Cross 167 at 168.

71 See Minister of Health and Social Welfare of the Republic of Liberia, "Interview with Walter T. Gwenigale Minister of Health and Social Welfare of the Republic of Liberia" (2013) 95:889 Intl Rev Red Cross 13 at 18–19.

72 *Ibid* at 19.

tion of PIL as a gendered system of law-– in view of its subjects, sources and material scope-– is well-established.[73] The historical development and philosophical underpinnings of IHRL, IHL, and ICL display blind spots when it comes to the needs and experiences of women. This also holds true for matters relating to maternal health. For example, the *de facto* hierarchy of rights and non-intrusion on issues involving state infrastructure and morals-– including on women's reproductive autonomy-– undermine a robust approach in IHRL. Likewise, the focal point of IHL has been the regulation of the means and methods of warfare, with limited recognition of how conflicts affect women.[74] Issues involving health care infrastructure and gendered harm beyond sexual violence are still not major concerns in IHL. Meanwhile, the gendered scope of international crimes and design of reparations in ICL have also been criticized.[75]

PIL is also fraught with fragmentation-– through the development of specialized regimes and regulatory systems-– which may leave certain pockets unregulated. IHRL, IHL, and ICL form a patchwork of regulations that apply in situations of peace, armed conflict, and post-conflict situations. While largely complementary, gaps in protection appear as a result of the distinctive features of these areas of law, such as the subjects of the regimes and their material, territorial, and temporal scope.

Gaps within regimes may, in part, be remedied through treaty interpretation. This includes the evolutive treaty interpretation method, particu-

---

[73] Hilary Charlesworth, Christine Chinkin & Shelley Wright, "Feminist Approaches to International Law" (1991) 85:4 Am J Intl L 613 at 621–635; Hilary Charlesworth & Christine Chinkin, *The Boundaries of International Law: A Feminist Analysis* (Manchester: Manchester University Press, 2000); Kelly Askin & Dorean Keonig, *Women and International Human Rights Law: Introduction to Women's Human Rights Issues* (Ardsley: Transnational Publishers, 1999); Karen Engle, "International Human Rights and Feminism: When Discourses Meet" (1992) 13:3 Mich J Intl L 517 at 519.

[74] Judith Gardam, "Women and the Law of Armed Conflict: Why the Silence" (1997) 46:1 Inti & CLQ 55 at 55.

[75] Michelle Jarvis & Judith Gardam, "The Gendered Framework of International Humanitarian Law and the Development of International Criminal Law" in Indira Rosenthal et al (eds) *Gender and International Criminal Law* (OUP 2022) at 72; Jonathan O'Donohue & Rosemary Grey, "'Gender-Inclusivity' in the International Criminal Court's First Reparations Proceedings" in Indira Rosenthal et al (eds) *Gender and International Criminal Law* (OUP 2022) at 306-307.

larly prominent in IHRL, which seeks to adhere to the object and purpose of treaties. The interpretation of certain IHL rules is also malleable, with concepts such as "humane treatment" developing "over time under the influence of changes in society."[76] Substantive equality is an increasingly important aspect in all the examined areas of law, sometimes requiring differential treatment of women. A gender-sensitive interpretation of provisions may support this objective and help concretize obligations to ensure a particular health service.

Systemic integration is also a means of reinforcing protection through clarifying and harmonizing abstract norms in these areas of law. Traditionally, the legal maxim of *lex specialis*=is used to resolve conflicts of norms, where the more specific rule is given preference when inconsistent with a general rule.[77] In its second function – as an interpretative tool – it applies when two norms are consistent with each other, but one rule is more detailed or specifically addresses the context in question.[78] Here, through means of interpretation, the specific rule may be viewed as an application of the general rule. Thus, a general rule may either be set aside, or both rules apply concurrently. However, as noted in the International Law Commission (ILC) study, even where the general rule is set aside, it remains in the background "providing interpretative direction to the special one."[79] The second approach is dubbed by the ILC as a "systemic view of the law"[80] and overlaps with systemic integration as treaty interpretation, reflected in Article 31 (3) (c) of the Vienna Convention on the Law of Treaties (VCLT).[81] The start-

---

[76] Jean-Marie Henckaerts & Louise Doswald-Beck for The International Committee of the Red Cross, *Customary International Humanitarian Law*, vol 1 (New York: Cambridge University Press, 2005) at 308 [Henckaerts & Doswald-Beck]. Evolutive treaty interpretation is permitted by the *Vienna Convention on the Law of Treaties*, 23 May 1969, 1155 UNTS 331 arts 31–33 (entered into force 27 January 1980) [VCLT].

[77] Study Group of the International Law Commission, *Fragmentation of International Law: Difficulties Arising from the Diversification and Expansion of International Law*, UNGA, 58th Sess, UN Doc A/CN.4/L.682 (2006) at paras 56–57.

[78] *Ibid.*

[79] *Ibid* at para 102.

[80] *Ibid* at para 104.

[81] VCLT, *supra* note 76 art 31(3)(c); See also the *American Convention on Human Rights*, 22 November 1969, 1144 UNTS 123 art 29(b) (entered into force

ing point of systemic integration is to treat different areas of international law as part of a greater whole and involves a non-hierarchical application of areas of law or rules.[82] This approach is particularly useful given the difficulty in determining which legal framework or rule is more specific in a certain instance. It also aids harmonization. Although systemic integration in the VCLT involves treaty disputes between parties bound by the rules in question, international bodies have applied it in a more expansive manner, including in general comments and case law.[83]

IHL is frequently assumed to be the *lex specialis* during armed conflict, given its contextual specificity. However, in certain instances, IHRL contains more detailed rules.[84] On occasion, norms appear to conflict in the two regimes.[85] Although IHRL and IHL share a common goal of protecting human dignity, the latter balances the principle of humanity with that of military necessity.[86] However, since genuine conflicts rarely arise between these areas, it is increasingly proposed that the most appropriate tool to address this relationship is systemic integration. For example, the International Committee of the Red Cross (ICRC) Customary Law Study considers that IHRL may "support, strengthen and clarify analogous principles of

---

18 July 1978). *African Charter on Human and Peoples'* Rights, 27 June 1981, OAU Doc CAB/LEG/67/3 art 61 (entered into force 21 October 1986).

82 Study Group of the International Commission, *supra* note 77 at para 414.

83 *Hassan v United Kingdom* [GC], No 29750/09 (16 September 2014) at para 102; *Prosecutor v Germain Katanga*, ICC-01/04-01/07, Judgment pursuant to article 74 of the Statute (7 March 2014) at para 47 (International Criminal Court, Trial Chamber II), online: [perma.cc/9SLF-H53C]; *The Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, HRC, 2004, UN Doc CCPR/C/21/Rev.1/Add 13 General Comment No 31 at para 11; *General Comment No 4: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5)*, February–March 2017 at para 63 (adopted at the 21st extra-ordinary session of the African Commission on Human and Peoples' Rights).

84 For example, concerning the right to a fair trial. See e.g. Henckaerts & Doswald-Beck, *supra* note 76 at 355-356.

85 For example, rules on detention. See *Hassan v United Kingdom, supra* note 83 at para 102.

86 Katharine Fortin, *The Accountability of Armed Groups Under Human Rights Law* (OUP, 2017) at 31.

international humanitarian law."[87] The parallel application of these two regimes has also been affirmed by the International Court of Justice (ICJ) on numerous occasions.[88] Additionally, UN treaty bodies and regional human rights law courts have noted the complementary relationship between the two bodies of law.[89] For example, the CEDAW Committee has emphasized that states' party obligations under the Convention on the Elimination of All Forms of Discrimination (CEDAW) continue to apply during armed conflict and periods of transition, alongside IHL.[90] Similarly, in several resolutions, the UN Security Council has connected issues of sexual violence and reproductive health in armed conflicts to both IHRL and IHL.[91]

As will be examined, much of the content on the right to health is developed in IHRL soft law sources. Systemic integration, as regulated in the VCLT, considers applicable law between the parties, which denotes binding sources. Nevertheless, in practice, soft law sources are often considered.[92] Given the abstract nature of human rights provisions, general comments provide valuable clarifying content and may represent emerging customary international law (CIL). Soft law sources are also frequently used when interpreting IHL. For example, the ICRC Customary Law Study references

---

87 Henckaerts & Doswald-Beck, *supra* note 76 at xxxvii.

88 See e.g. *Legal Consequences of the Construction of a Wall in Occupied Palestinian Territory*, Advisory Opinion, [2004] ICJ Rep 136 at paras 106, 112 [The Wall Case].

89 See e.g. *General Comment No 36: Article 6: Right to Life*. UNHRC, 2018, UN Doc CCPR/C/GC/36 (2019) at para 64 [UNHRC, "General Comment No 36"]; *Case of the Mapiripán Massacre (Colombia)*, (2005), Inter-Am Ct HR (Ser C) No 134 at para 115.

90 *General Recommendation No 28 on the Core Obligations of States Parties under Article 2 of the Convention on the Elimination of all forms of Discrimination Against Women*, CEDAW, UN Doc CEDAW/C/GC/28 (2010) at para 11.

91 See e.g. *Resolution 2467*, UNSC, 2019, UN Doc S/RES/2467 Res 2467 at para 31 [UNSC Res 2467].

92 See e.g. *Opuz v Turkey*, No 33401/02, [2009] 50 EHRR 28 at paras 74–75. See generally Vito Todeschini, "The Impact of International Humanitarian Law on the Principle of Systemic Integration" (2018) 23:3 J Confl & Sec L 359 at 362; Jan Klabbers, "Reluctant *Grundnormen*: Articles 31(3)(c) and 42 of the Vienna Convention on the Law of Treaties and the Fragmentation of International Law" in Matthew Craven et al, eds, *Time, History, and International Law* (Boston: Martinus Nijhoff publishers, 2007) at 159.

general recommendations by the CEDAW Committee to interpret the scope of IHL rules to address the specific needs of women in armed conflict.[93] The following chapter will thus explore the current regulation of maternal health care – focusing on EmOC and safe abortion – from a systemic viewpoint with the overarching objective of developing effective standards for preventing maternal mortality.

B. International human rights law

1. General obligations under the right to health

As maternal health care involves a range of services during pregnancy, delivery and post-birth, it falls within the scope of various human rights. The type of right involved affects not only the stringency and content of state obligations but also its convergence with IHL and ICL. Certain rights and obligations more directly overlap.

A limited number of treaties explicitly ensure a right to maternal health care, such as the CEDAW and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).[94] However, maternal health has mainly been addressed as an aspect of the broader right to health, which includes sexual and reproductive rights.[95] The

---

93 Henckaerts & Doswald-Beck, *supra* note 76 at 477.

94 CEDAW, "General Recommendation No 30", *supra* note 49 at para 52; *Protocol to the African Charter on human and Peoples' Rights of Women in* Africa, 1 July 2003, OAU Doc CAB/LEG/66.6 art 14 (entered into force 25 November 2005)[Maputo Protocol]; *International Covenant of Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3 art 10(2) (entered into force 3 January 1976) [ICESCR] also states that 'special protection should be accorded to mothers during a reasonable period before and after childbirth'. See also *Convention on the Rights of the Child*, 20 November 1989, 1577 UNTS 3 art 24(d) (entered into force 2 September 1990).

95 See *Report of the International Conference on Population and Development*, UNFPA, 1994, UN Doc A/CONF.171/13 at para 7.2. See also *Beijing Declaration and Platform for Action, The Fourth World Conference on Women, UNW, 1995, 50th sess, UN Doc A/CONF.177/20* at paras 89–105.

right to health is recognized in international human rights law treaties, including the International Covenant on Economic, Social and Cultural Rights (ICESCR).[96] Meanwhile, standards for maternal health care have been more concretely delineated through the work of the UN Committee on Economic, Social and Cultural Rights (CESCR) and the CEDAW Committee.[97] Even when health care is addressed within the scope of civil rights, the general principles established in relation to the right to health have influenced the content of obligations.[98]

The right to health provides a comprehensive framework for preventing maternal mortality. It comprises two dimensions: access to health care services and ensuring the underlying conditions necessary for good health since factors such as poverty and structural discriminatio, impede the fulfillment of the right.[99] Health systems are thus viewed as institutions embedded in social and political structures that may reflect and enforce patterns of inequality. In view of the causes and exacerbating factors of maternal mortality, this is essential. However, while this holistic approach ensures the development

---

96 ICESCR, *supra* note 94 art 12. See also *International Convention on the Elimination of All Forms of Racial Discrimination*, 21 December 1965, 660 UNTS 195 art 5(e)(iv) (entered into force 4 January 1969); *African Charter on Human and Peoples' Rights*, 27 June 1987, OAU Doc CAB/LEG/67/3 art 16 (entered into force 21 October 1986); OAS, General Assembly, 18th Sess, *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights*, OEA/Ser.A/44 (1988) art 10 [Protocol of San Salvador].

97 CESCR, *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)*, UNESC (2016) UN Doc E/C.12/GC/22 at para 45 [CESCR, "General Comment No 22"]; CEDAW, *General Recommendation No 24: Article 12 of the Convention (Women and Health)*, UNESC 20th Sess, UN Doc A/54/38/Rev.1 (1999) at para 31(c) [CEDAW, "General Recommendation No 24"]. See also OAS, Inter-American Commission on Human Rights, *Access to Maternal Health Services from a Human Rights Perspective* (2010) OEA/Ser.L/V/II. Doc. 69 at paras 42-43 [IACmHR, '*Access to Maternal Health Services*'].

98 See e.g. *Xakmok Kasek v Paraguay* (merits, reparations and costs) IACtHR Series C No 214 (24 August 2010) at paras 233-234 [Xákmok]; *Annual Report of the Inter-American Court of Human Rights*: 1996, OEA/Ser.L/V/III.19/ doc.4 (1997) 179; *Annual Report of the Inter-American Court of Human Rights:* 2010, OEA/Ser.L/V/II.Doc.5 (2011) 1372.

99 CESCR, "General Comment No 14", *supra* note 6 at para. 9.

of more effective measures of prevention, it has also made the concretization of the right and its implementation more complex.[100] For instance, it entails that the right to health is related to and dependent on the realization of a range of other human rights like the right to education, food and water, and requires the involvement of actors beyond the health sector.[101]

Given women's biological and socio-cultural differences, the CESCR emphasizes the need for gender-sensitivity in addressing the right to health.[102] A section in General Comment No. 14 dedicated to maternal, child and reproductive health care expounds on Art. 12 (2) (a) and affirms obligations to ensure maternal health services, including access to pre- and postnatal care and emergency obstetric services.[103] The Committee in General Comment No. 22 also notes the connection between maternal mortality and the lack of access to abortion and emergency obstetrics care.[104]

Meanwhile, obligations have been formulated in the form of respecting, protecting and fulfilling the right to health while bearing in mind the availability, accessibility, acceptability and quality (AAAQ) model.[105] Non-discrimination is a guiding principle for obligations to *respect* the right to health.[106] More specifically, the CEDAW Committee, the UN Human Rights Committee (UNHRC) and the CESCR have held that this includes not limiting access to and criminalizing medical procedures only needed by women,

---

100 Alicia Ely Yamin & Andres Constanti, "A long Winding Road: The Evolution of Applying Human Rights Frameworks to Health" (2017) 49:1 Geo J Intl L 191 at 204.

101 *CESCR,* "General Comment No 14", *supra* note 6 at para 11.

102 *Ibid* at para 20.

103 *Ibid* at para 14.

104 CESCR, "General Comment No 22", *supra* note 97 at para 10.

105 *Ibid* at para 12. According to the UN Special Rapporteur on the Right to Health, the AAAQ standard is especially relevant for policy-making, while the identification of obligations to respect, protect and fulfil are more suited to legal analysis. See Commission on Human Rights, *Report of the Special Rapporteur: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UNESC, 2004, UN Doc E/CN.4/2004/49/Add.1 at para 39 [Commission on Human Rights].

106 CESCR, "General Comment No 14', *supra* note 6 at para 18.

such as abortion.[107] Furthermore, states may not restrict access to health care services as a punitive measure during armed conflict nor obstruct aid organizations in their tasks.[108] The obligation to respect also requires the acceptance of essential health-related services offered by foreign donor organizations and the international community, including sexual and reproductive health services, implying a duty to consent.[109] These obligations largely correlate with IHL rules.

In order to *protect* the right to health, states must ensure that medical practitioners and other health professionals meet appropriate standards of education, skills and ethical codes of conduct.[110] According to the CEDAW Committee, the latter includes health services that are sensitive to women's needs and perspectives.[111] As noted, violence and insecurity generated by armed conflict may reduce patients' security in accessing health care and cause the migration of health care personnel. The state must take steps to ensure security in such contexts.[112] This also generally corresponds with IHL rules.

Furthermore, states must offer public health infrastructure guaranteeing sexual and reproductive health services, particularly in rural areas, to adequately fulfil the right to health.[113] It involves ensuring a sufficient number of maternal health care facilities, subject to equitable distribution and within safe physical reach for all. This includes a system of urgent medical care,[114] regular screening programs and treatments, preferably at commun-

---

107 CEDAW, "General Recommendation No 24", *supra* note 97 at para 14; UNHRC, 'Technical Guidance', *supra* note 36 at para 30; CESCR, "General Comment No 22", *supra* note 97 at para 57.

108 CESCR, "General Comment No 14", *supra* note 6 at para 34; *Cyprus v Turkey,* No 25781/94, [2001] IV ECHR 1, 35 EHRR 731 at para 219.

109 CESCR, "General Comment No 22", *supra* note 97 at para 41.

110 CESCR, "General Comment No 14", *supra* note 6 at para 35.

111 CEDAW, "General Recommendation No 24", *supra* note 97 at para 22.

112 CESCR, "General Comment No 14", *supra* note 6 at para 12(b).

113 *Ibid; UNHR, Preventable Maternal Mortality and Morbidity and Human Rights, supra* note 4 at para 43.

114 CESCR, "General Comment No 14", *supra* note 6 at para 16.

ity level,[115] as well as access to and equitable distribution of safe abortion services and quality post-abortion care.[116] The CEDAW Committee has also noted the prevalence of obstetric fistula among rural women, as a result of a lack of access to emergency health care capable of performing C-sections, thus obliging states to ensure such services.[117] Accordingly, a range of measures are required to ensure both EmOC and safe abortion as an aspect of the right to health. However, certain contextual factors affect the content of obligations.

The ICESCR sets out general limitation clauses *vis-à-vis* its rights. relevantly– and in contrast to civil and political rights– socio-economic rights allow for progressive implementation by the state party, to the maximum of its available resources, albeit through deliberate, concrete and targeted steps.[118] Progressive implementation acknowledges the economic realities of states, bearing in mind the substantial cost of implementing, for example, a widely accessible health care system. In terms of EmOC and abortion services, providing good quality care is less costly than treating complications, such as those arising from unsafe abortions.[119] Preventable obstetric emergencies overburden health care systems and stretch resources.[120] Additionally, BEmOC and abortions services can generally be performed through primary health care.

As noted, armed conflict constrains state resources. With IHRL implementation relative to available resources, it is implied that retrogressive measures may be allowed in circumstances of diminished financial means. However, in relation to sexual and reproductive health, there is a strong presumption against retrogressive measures, including laws criminalizing

---

115 *Ibid* at para 17.

116 CESCR, "General Comment No 22", *supra* note 97 at paras 13, 21, 28.

117 *General recommendation No 34 on the rights of rural women*, UN CEDAW (2016) UN Doc CEDAW/C/GC/34 at paras 37, 39 (a) [CEDAW, "General Recommendation No 34"].

118 ICESCR, *supra* note 94 art 2, 4. Art 4 also allows for limitations "…for the purpose of protecting the general welfare". Limitations on the basis of such aims as national security are thus generally not legitimate *per se*. *See The Wall Case*, *supra* note 88 at para 136.

119 WHO, *Abortion Care Guideline*, *supra* note 26 at 15.

120 *Ibid*.

certain services, policies revoking public health funding and the removal of sexual and reproductive health medication.[121] States must also ensure that retrogressive measures are temporary and do not disproportionately affect disadvantaged groups, which includes women.[122] Accordingly, if the overall budget of the state decreases, resources for sexual and reproductive health programmes may not be reduced unless the state demonstrates that it has taken all reasonable measures to avoid it.[123]

2. Core obligations – the right to health and beyond

While socio-economic rights in general allow for progressive implementation, certain aspects require immediate measures.[124] There is a minimum level of protection that must be guaranteed in all circumstances, including during armed conflict. Core obligations are listed in General Comment No. 3 and General Comment No. 14 of the CESCR, which ensure minimum levels of each right, including essential primary health care, non-discrimination, equitable distribution of health facilities and the adoption of a national public health strategy.[125] While primary health care is thus considered a core obligation, it is not defined. In fact, the Committee notes that the concepts of primary, secondary and tertiary health care are futile, since they frequently overlap.[126] However, General Comment No. 14 references the Alma-Ata

---

121 CESCR, "General Comment No 22", *supra* note 97 at para 38; CESCR, *'Concluding observations of the Committee on Economic, Social and Cultural Rights: Democratic Republic of the Congo'*, UNESC, 43rd Sess, UN Doc E/C.12/COD/CO/4, (2009) at para 16.

122 CESCR, "General Comment No 22", *supra* note 97 at para 38. See e.g. Commission on Human Rights, *supra* note 105 at para 37 for a delineation of vulnerable groups.

123 UNHRC, "Technical Guidance", *supra* note 36 at para 47 (c).

124 *Ibid* at para 30.

125 CESCR, *General Comment No 3: The Nature of States Parties' Obligations (Art. 2, Para. 1 of the Covenant),* UNHCR, 5th sess, UN Doc E/1991/23 (1990) at para 10; CESCR*,* "General Comment No 14", *supra* note 6 at para 43. See also *Protocol of San Salvador*, *supra* note 96 art 10, which similarly requires primary health care; UNHRC, 'Technical Guidance', *supra* note 36 at para 27.

126 CESCR, "General Comment No 14", *supra* note 6 at n 9.

Declaration as a guide to the content of core obligations.[127] While the Declaration affirms that maternal health care is part of primary health care, it does not mention specific services.[128] In turn, the Cairo Programme of Action of 199-, which also builds on the Alma-Ata Declaratio-, lists emergency obstetrics care and referral systems for complications during pregnancy, childbirth and abortion as services included in primary health care.[129]

In contrast, the CESCR holds that it is "of comparable priority" to "ensure reproductive, maternal (prenatal as well as postnatal) and child health care".[130] Such care is considered separate from essential primary health care. Similarly, the CEDAW Committee, in relation to the right to health, requires states parties to "…ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources."[131] They are thus not considered core obligations subject to immediate realization. This means that while BEmOC is increasingly part of primary health care, there is no explicit support for it being a core obligation in relation to CEDAW and the ICESCR. Meanwhile, trauma care and surgery involving specialized training of health care personnel and advanced technology fall outside the scope of the minimum core of the right, as they are often offered at the second or tertiary level of health care.[132] This would include CEmOC. A seemingly pragmatic approach to core obligations is accordingly taken, with the cost of EmOC allowing for progressive implementation despite being essential in preventing maternal mortality.

---

127 *Ibid* at para 43. See also *Text of Alma Ata Agreements,* 12 September 1978, online: <who.int> [https://perma.cc/GC28-23BK] (adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, co-sponsored by WHO and UNICEF) [Declaration of Alma-Ata].

128 *Ibid* at para VII (3).

129 *Programme of Action: Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994,* UNFPA, UN Doc E/25,000/2004 at para 8.22.

130 CESCR, "General Comment No 14", *supra* note 6 at para 44.

131 CEDAW, "General Recommendation No 24", *supra* note 97 at para 27.

132 WHO, *The World Health Report 2008: Primary Health Care: Now More Than Ever* (WHO, 2008) at 55; Richard Skolnik, *Global Health 101* (Jones & Bartlett Learning, 2012) at 92.

At the same time, equality is a core aspect of the right to health, which strengthens the argument for including EmOC in these minimum standards.[133] A range of international bodies affirm that the concept of equality requires the acknowledgment of the specific health needs of women and ensuring appropriate services to meet those needs.[134] Both biological and social differences between men and women must be recognized. For example, the Inter-American Court of Human Rights (IACtHR) has noted that sexual and reproductive health has special implications for women owing to their biological capacity to conceive and give birth.[135] Excessive maternal mortality rates are considered a result of historic gender inequality[136] and statistics demonstrating such may indicate a violation of the non-discrimination principle *per se*.[137] The CEDAW Committee and the IACtHR have also in case law categorised failures to ensure adequate emergency obstetrics care as sex discrimination, detailing obligations aligned with CESCR General Comment No. 14.[138] The IACtHR has in several cases categorised the failure to ensure timely EmOC as a form of obstetric violence and sex discrimination.[139] In doing so, both bodies have specified that states must provide adequate, specialized, and differentiated health services during pregnancy, childbirth and for a reasonable period after delivery, to guarantee the mother's right to health and to prevent maternal mortality and morbidity.[140] Meanwhile, an intersectional approach to equality is integral. For

---

133 CESCR, "General Comment No 14", *supra* note 6 at para 43 (a).

134 CESCR, "General Comment No 22", *supra* note 97 at para 25; CEDAW, "General Recommendation No 24", *supra* note 97 at paras 2, 12(a); CEDAW, *Alyne da Silva Pimentel Teixeira v Brazil,*Communication No. 17/2008 (27 September 2011) UN Doc CEDAW/C/49/D/17/2008 at para 7.3 [*Alyne da Silva Pimentel Teixeira v Brazil*].

135 *Manuela Case (El Salvador)* (2021), Inter-Am Ct HR (Ser C) No 441 at para 193 [*Manuela Case*]

136 IACmHR, '*Access to Maternal Health Services*', *supra* note 97 at para 83 .

137 CEDAW, "General Recommendation No 24", *supra* note 97 at para 17.

138 *Xákmok*, *supra* note 98 at paras 233–234; *Alyne da Silva Pimentel Teixeira v Brazil* , *supra* note 135 at para 7.2.

139 *Manuela Case*, *supra* note 136 at paras 201, 259; *Brítez Arce Case (Argentina)* (2022), Inter-Am Ct HR (Ser C) No 474 at paras 75-81.

140 *Xákmok*, *supra* note 98 at para 233;, *Alyne da Silva Pimentel Teixeira v Brazil, supra* note 135 at para 7.8.

example, particular attention must be given to vulnerable groups, including women in armed conflict, refugees and internally displaced women.[141] The CEDAW Committee and the IACtHR have similarly addressed the interplay between gender, socio-economic backgrounds and ethnicity as factors affecting maternal mortality.[142] Vulnerability enhances the obligations of states, for example, in ensuring access to care.

Furthermore, there is a link between these core obligations-– as essential conditions for survival – and the right to life.[143] UN treaty bodies and regional human rights law courts have affirmed obligations to ensure access to EmOC within the scope of the right to life. For example, the European Court of Human Rights (ECtHR) has held that while the European Convention on the Protection of Human Rights and Fundamental Freedoms (ECHR) does not guarantee a right to free medical care or specific medical services, a lack of access to emergency obstetrics care may under certain circumstances contravene the right to life.[144] The IACtHR has also in several cases held states accountable for failing to ensure access to maternal health care, and thus necessary conditions for survival, as an aspect of the right to life. [145] This has mainly involved particularly vulnerable groups, such as indigenous populations living in poor areas with high maternal mortality rates.[146] The UNHRC has likewise noted in concluding observations and general comments that high rates of maternal mortality related to poor qual-

---

141 CEDAW, "General Recommendation No 24", *supra* note 97 at para 16.

142 *Alyne da Silva Pimentel Teixeira v Brazil, supra* note 135 at para 7.7; *Xákmok*, *supra* note 98 at paras 232–233.

143 Alexander Breitegger, "The Legal Framework Applicable to Insecurity and Violence Affecting the Delivery of Health Care in Armed Conflicts and Other Emergencies" (2013) 95 Intl Rev Red Cross 83 at 99.

144 *Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 UNTS 221; (entered into force 3 September 1953) [ECHR]. See, for example, *Mehmet Sentürk and Bekir Sentürk v Turkey,* No 13423/09*,* [2013] ECHR 1, 60 EHRR 4 at paras 95-97.

145 *Xákmok* , *supra* note 98 at para 233; *Sawhoyamaxa Indigenous Community v Paraguay (merits, reparations, and costs),* IACtHR Series C No 140 (29 March 2006) at para 177; *Yakye Axa Indigenous Community v Paraguay (merits, reparations, and costs),* IACtHR Series C No 125 (17 June 2005) at para 221.

146 *Ibid.*

ity of health care and unsafe abortions contravene the right to life, requiring access to emergency obstetrics care and safe abortion.[147]

While the core of the right to health involves primary health care, which *may* encompass BemOC, additional forms of care, such as CEmOC, are necessarily required by the right to life and the principle of non-discrimination. Through this patchwork of soft law sources and case law, obligations to ensure both BEmOC and CEmOC tentatively appear. Given that the right to life and the prohibition on discrimination are non-derogable and to be implemented immediately, it should be explicitly recognized that such services are encompassed within core obligations of the right to health. The added value of addressing this within the right to health is, as mentioned, the holistic approach to prevention measures. Nevertheless, states maintain broad discretion in terms of their health care infrastructure, regardless of whether it is addressed within socio-economic or civil rights.

As for access to abortion, the core obligations in CESCR General Comment No. 22 include "taking measures" to prevent unsafe abortions,[148] whether this includes the legalization of abortion or, for example, aiding access when legality is unclear. Nevertheless, the CESCR considers the denial of abortion to be a form of discrimination in relation to the right to health; that is, a violation of a core obligation.[149] At times, the language used by the CEDAW Committee indicates a degree of choice in implementation for states: "[w]hen *possible*, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion,.[150] However, the Committee has increasingly called for access to safe abortion, for example, in humanitarian settings, and connected unsafe abortions to preventable maternal mortality.[151] In the more recent General Recommendation No. 35, the Committee denotes the criminaliza-

---

147 UNHRC,"General Comment No 36", *supra* note 89 at para 26; *Concluding Observations of the Human Rights Committee: Democratic Republic of the Congo,* UNHRC, 86th Sess, UN Doc CCPR/C/COD/CO/3 (2006) at para 14.

148 CESCR, "General Comment No 22", *supra* note 97 at para 49 (a), (c), (e).

149 *Ibid* at para 34.

150 CEDAW, "General Recommendation No 24", *supra* note 97 at para 31 (c). Emphasis added.

151 CEDAW, "General Recommendation No 30", *supra* note 49 at para 52 (c); *Summary of the Inquiry Concerning the Philippines under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimi-*

tion of abortion and the denial or delay of safe abortion and/or post-abortion care as forms of gender-based violence and thus discrimination.[152]

Beyond this broader approach-– linking safe abortion to health and non-discrimination-– access to abortion has solely been affirmed as a human right under specific circumstances. For example, a right to access abortion upon request has been rejected by the ECtHR, while obliging states to ensure access in states that allow abortion, that is, a procedural right.[153] More support exists in instances of a threat to the life or health of the woman. This is codified in the Maputo Protocol[154] and has been affirmed by the UN Committee on Torture (CAT),[155] the UNHRC,[156] the CEDAW Committee,[157] and the IACtHR [158] as an aspect of the right to life, the right to privacy and the prohibition on inhuman or degrading treatment. Nevertheless, this approach primarily affirms a right to access abortion when there is an existing threat to the health of a woman, as opposed to considering the lack of abortion itself as a factor contributing to maternal mortality.

Furthermore, the Maputo Protocol specifically obliges states to provide for access to abortion in cases of rape or incest.[159] A similar approach has

---

nation against Women, UNCEDAW, 2015, UN Doc CEDAW/C/OP.8/PHL/1 at para 33.

152 *General Recommendation No 35 on Gender-Based Violence against Women, Updating General Recommendation No 19*, UNCEDAW, 2017, UN Doc CEDAW/C/GC/35 at para 18 [CEDAW, "General Recommendation No 35"].

153 *A, B and C v Ireland,* No 25579/05, [2010] ECHR 1, 53 EHRR 13 at para 249.

154 Maputo Protocol, *supra* note 94 art 14(2)(c).

155 See, for example, *Concluding Observations of the Committee against Torture: Nicaragua,* UNCAT, 42nd Sess, UN Doc CAT/C/NIC/CO/1 (2009) at para 16.

156 UNHRC, "General Comment No 36"*, supra* note 89 at para 8; *Communication No 1153/2003*, UNHRC, 85th Sess, UN Doc CCPR/C/85/D/1153/2003 (2005) at para 6.4.

157 CEDAW, "General Recommendation No 35", *supra* note 153 at para 18.

158 *Provisional Measures with Regard to El Salvador: Matter of B* (2013)*,* Inter-Am Ct HR at para 17, 52:6 ILM 1285; OAS, Inter-Am Comm HR, *Precautionary Measure MC 43-10- "Amelia", Nicaragua (February 26, 2010)*, online: <oas.org> [https://perma.cc/Y9XG-622F].

159 Maputo Protocol, *supra* note 94 art 14(2)(c).

been adopted by a range of UN treaty bodies, also in connection to the right to privacy and the prohibition of inhuman or degrading treatment.[160] Sexual violence is prohibited in international human rights law, both in treaty law and CIL.[161] The health consequences of sexual violence are both physical and psychological and may involve unwanted pregnancy for female victims. A right to abortion is in this view thus partly a form of remedy.

Although the approaches affirming a limited right to abortion have served to strengthen the rights-based arguments for ensuring access, a distinction between different categories of pregnant women is upheld. In view of the broader consequences of unsafe abortion – and the principle of equality – women's health is a more suitable prism through which the right to abortion should be addressed.

3. The development approach – concretising obligations?

Whereas the previously mentioned sources affirm a right to emergency obstetrics care and abortio– under certain circumstances– the delineation of the quantity and quality of such care is often limited, even with AAAQ standards. For example, while a core obligation of the right to health is "equitable" distribution of health care facilities, what this entails is not specified. This reflects broad global differences in health care infrastructure and the considerable flexibility for states in choosing the means of implementation. Nonetheless, access to maternal health care is increasingly addressed also in relation to developmental goals and humanitarian aid, including the UN SDGs.[162] It is in such contexts mainly evaluated in a quantitative manner,

---

160 CESCR, "General Comment No 22", *supra* note 97 at para 45; *L. C. v Peru*, CEDAW *Communication No 22/2009*, , 50th Sess, UN Doc CEDAW/C/50/D/22/2009 (2011) at para 8.18; *Concluding Observations: Paraguay,* UNCAT, 47th Sess, UN Doc CAT/C/PRY/CO/4-6 (2011) at para 22.

161 See, for example, *Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women: Convention of Belem do Para*, 9 June 1994, 33 ILM 1534 at art 1, 2 (entered into force 5 March 1995); *Istanbul Convention: Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence*, 11 May 2011, ETS No 210 at art 36 (entered into force 1 August 2014); Maputo Protocol, *supra* note 94 arts 3(4), 11(3); CEDAW, *"General Recommendation No 35"*, *supra* note 153 at para 2.

162 UNGA Transforming Our World, *supra* note 5; WHO, *Reproductive Health*

with implementation monitored in relation to statistical goals of reducing maternal mortality. The broad human rights-based approach, considering reproductive rights in light of structural gender constraints – involving layers of actors and obligations – thus to a degree conflicts with the development approach.[163] However, while the latter may fail to address the structural causes of violations an, arguabl, leads to narrow interventions, the statistical indicators concretize minimum standards for operationalizing health care.

For instance, the WHO has developed indicators for effective emergency obstetrics care that evaluate the availability and geographical distribution of EmOC facilities. The minimum acceptable level of EmOC services includes at least four basic and one comprehensive EmOC facility per 500,000 people.[164] The number of women with major obstetric complications as well as the quantity of caesarean sections in proportion to all births and direct obstetric fatality rates are also recorded.[165] Similar indicators exist for safe abortion service focusing on the accessibility and quality of care in addition to outcomes, including maternal deaths linked to unsafe abortions.[166] As such, mainly social science methods ary used to evaluate causal factors between laws, policies and health care.[167] WHO handbooks, particularly relating to humanitarian settings, also include specifications of medical treatments, necessary medical and technical equipment and the content of education on maternal health care for staff.[168] Such sources are naturally not binding nor generally linked to specific human rights law treaties. In fact, human rights are rarely mentioned in the handbooks. Nevertheless, given their technical specification, they may aid in further concretizing state obligations. The CESCR, for example, refers to WHO indicators in

---

Strategy, *supra* note 24 at 22; Commission on Human Rights, *Report on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UNESC, 62nd Sess, UN Doc E/ CN.4/2006/48 (2006) at paras 54–56.

163 Yamin & Constantin, *supra* note 100 at 211.

164 WHO, *Monitoring Emergency Obstetric Care*, *supra* note 18 at 5.

165 *Ibid* at 2.

166 *WHO Safe Abortion Guidance*, *supra* note 32 at 75.

167 Yamin & Constantin, *supra* note 100 at 208.

168 See, for example, WHO, *Safe Abortion Guidance*, *supra* note 32; WHO, *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception* (WHO, 2015); WHO, *Medical Management of Abortion* (WHO, 2018).

General Comment 14 as a means of measuring implementation of the right to health.[169] These areas of law and policy are thus mutually reinforcing on this issue. while IHRL takes a holistic approach by addressing both the underlying conditions necessary for good health and access to health care services, certain aspects undermine the effectiveness of IHRL standards in preventing maternal mortality. Access to emergency obstetrics care and safe abortion are increasingly affirmed in relation to various human rights, including the right to health and the right to life, in conjunction with the non-discrimination principle. However, such forms of care have not been recognized as core obligations in relation to the ICESCR, abortion is primarily addressed as a remedy to sexual violence – as opposed to health – and the broad flexibility for states in implementation weakens the realization of essential care.

IV. International humanitarian law

A. Protecting the wounded and sick

As noted, armed conflict heightens the need for maternal health care while also undermining access to care. This contextual vulnerability has been addressed in IHRL, affecting the content of state obligations. Meanwhile, IHL is generally *lex specialis* during armed conflict, with the distinctive characteristics of IHL impacting the extent to which maternity health care is regulated. Nevertheless, the more rapid development of IHRL, in part through soft law sources, entails that it may inform related concepts in IHL.

IHL aims to limit the effects of armed conflict by restricting the means and methods of warfare. In contrast to IHRL, IHL does not protect all individuals on the basis of their inherent dignity but rather persons with a particular status, such as civilians, medical personnel and persons *hors de combat*. Parties to an armed conflict are the primary duty-bearers, including non-state armed groups in NIACs. However, the main responsibility for meeting the needs of the civilian population in an armed conflict rests on the party in control of the territory.[170] Meanwhile, IHL rules affecting health

---

169 CESCR, "General Comment No 14", *supra* note 6 at paras 57-58.

170 See *Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts*, 8

care in armed conflict are complex and engage multiple actors, including parties to the conflict, humanitarian organizations and health care professionals. Not only is the application of international standards involved but also, to a certain extent, consideration of domestic laws and policies.[171]

Protecting the medical mission is at the core of IHL. However, apart from situations of occupation, IHL does not generally include obligations to uphold a particular type of health service or care of a certain standard.[172] Protection is granted to the "wounded and sick" in both international armed conflicts (IACs) and NIACs, that is, it does not apply to civilians *per se*. The provisions in Additional Protocol I (AP I) and Additional Protocol II (AP II) are more specific than those in the Geneva Conventions (GCs) and are largely considered to reflect CIL, including in the interpretation of corresponding concepts and obligations in the GCs.[173] The wounded and sick are in AP I defined as "'persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care…".[174]

The "wounded and sick" expressly encompass maternity cases, such as infirm or expectant mothers, who may be in need of medical assistance.[175]

June 1977, 1125 UNTS 609 (entered into force 7 December 1978) [AP II]. For example, in art 1 (1) AP II it is specified that non-state actors must exercise such control, in order to be able to implement the provisions of the Protocol. During occupation, the occupying state also has more far-reaching obligations.

171 Breitegger, *supra* note 144 at 87.

172 The law of occupation contains specific rules establishing positive obligations of the occupier to ensure medical supplies for the population, to the fullest extent of the means available to it. *See* Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) [GC IV], arts 55-57; *Protocol Additional to the Geneva Conventions of 12 August 1949 and Relating to the Protection of Victims of International Armed Conflicts*, 8 June 1977, 1125 UNTS 3 (entered into force 7 December 1978) [AP I], art 69.

173 Henckaerts & Doswald-Beck, *supra* note 76 at 400–01. *See* also, Gilles Giacca, "The Obligations to Respect, Protect, Collect and Care for the Wounded, Sick and Shipwrecked" in Andrew Clapham et al, eds, *The 1949 Geneva Conventions: A Commentary* (Oxford: Oxford University Press, 2015) at 799 [Giacca].

174 AP I, *supra* note 173, art 8 (a).

175 As seen in GC IV, *supra* note 173, art 16; AP I, *supra* note 173, art 8(a); In-

Maternity cases do not need to be either wounded or sick in the general sense but are included based on the presumption that they cannot partake in hostilities.[176] As noted in the commentary, this does not entail, for example, that expectant mothers are in urgent need at the time, but "…may *at any moment* necessitate immediate medical care."[177] While the categorization of expectant mothers as "wounded and sick" pathologizes pregnancy and childbirth, it in practice connotes individuals who may need care. In Article 7(2) of AP II, it is further specified that the medical care given relates to the person's "condition," with the ICRC noting that it is'"irrelevant whether the need for care arises from a medical condition that pre-dates the conflict or is linked to, even if not caused by, the conflict."[178] This stems from the principle of humanity - which"does not allow for such distinction" - and the requirement that the wounded and sick do not participate in hostilities.[179]

---

ternational Committee of the Red Cross, *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949* (Leiden: Martinus Nijhoff Publishers, 1987) at para 4637 [ICRC, *Commentary on the Additional Protocols*].

176 Annyssa Bellal, "Who Is Wounded and Sick?" in Andrew Clapham et al, eds, *The 1949 Geneva Conventions: A Commentary* (Oxford: Oxford University Press, 2015) 757 at 764 [Bellal].

177 ICRC, *Commentary on the Additional Protocols*, *supra* note 176 at para 305, commenting on the terminology of AP I, *supra* note 173, art 8. Emphasis added.

178 ICRC, *Commentary on the First Geneva Convention*, Common Art 3 GC I (Cambridge: Cambridge University Press, 2016) at para 743, online: <ihl-databases.icrc.org> [https://perma.cc/24NG-SNGT] [ICRC, *First GC Commentary*].

179 Bellal, *supra* note 177 at 762, 764.

B. Defining "care"

The wounded and sick are the beneficiaries of certain types of protection including evacuation, protection from attack and care. In terms of care, the types of medical treatment required are not concretized. Rather, the wounded and sick must'"receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition."[180] The form of medical care thus depends on the condition of the person, for example, the severity of their injuries.[181] It may range from first aid treatment to more complex surgeries. "Adequate care" to the wounded and sick is in the commentary to Art. 8 AP II specified as first aid given on the spot,[182] but also entails, for instance, handing over the wounded and sick to a medical unit or ensuring their transport to a hospital or specialized treatment center where they can be adequately cared for.[183] Commentaries also note that "care" must be interpreted broadly, to include not only treatment but also diagnosis, vaccination or advice.[184]

In terms of standards of care, medical ethics - such as ensuring medical neutrality, doing no harm to the patient and respecting the rights and preferences of the wounded and sick – are guiding principles. Common Article 3 in the GCs prohibits adverse distinction, that is, on any grounds other than medical urgency.[185] Whereas certain provisions guarantee women'"treatment as favourable as that granted to men,"[186] others require distinction, given the reproductive differences between men and women. For example, it is provided in GC I that'"women shall be treated with all consideration due

---

[180] Art 10 (2) AP I, *supra* note 173; AP II *supra* note 164, art 7 (2). "Adequate care" is guaranteed in AP II, *supra* note 171.

[181] ICRC, *First GC Commentary*, s*upra* note 179 at para 1381 (art 12).

[182] ICRC, *Commentary on the Additional Protocols*, *supra* note 176 at para 4655; AP I, *supra* note 173, art 8.

[183] *Ibid*.

[184] Giacca, *supra* note 174 at 789, para 32; ICRC, *First GC Commentary,* s*upra* note 179 at para 767 (Common Art. 3 GC I).

[185] ICRC, *First GC Commentary*, s*upra* note 179 at paras 764-765 (Common Art. 3 GC I).

[186] *Geneva Convention Relative to the Treatment of Prisoners of War*, 12 August 1949, 75 UNTS 135, at art 14 (entered into force 21 October 1950)[GC III].

to their sex" when wounded or sick.[187] According to the ICRC, this entails that "…their specific needs with regard to hygiene, ante- and post-natal care and gynaecological and reproductive health…" must be taken into account by the parties to the conflict.[188] This in turn requires consideration of how the "social, economic, cultural or political context" – including discrimination and stigma - may affect access to care, an aspect of the three-delay model.[189] The ICRC has also interpreted Common Article 3 to mean that the specific needs of a person may require a distinction in treatment in order to provide similar standards of care.[190] This is likewise reflected in medical ethics, where account must be taken of the specific health needs of women.[191] These standards not only recognise inherent differences between men and women in relation to care, but allow for the consideration of how armed conflict heightens the need for certain forms of medical treatment, such as EmOC and safe abortion.

However, although these provisions and commentaries give certain direction in terms of the services required, they are still broadly composed. In order to concretize such standards, and in view of the complementary nature of IHRL and IHL, calls have been made to align "care" in IHL with the minimum core obligations of the right to health in the ICESCR, given that such are non-derogable, that is, fully applicable in times of armed conflict.[192]

As noted, essential primary health care is a core obligation in IHRL, which *may* encompass BEmOC, although not explicitly mentioned. IHRL may also inform the content of the non-discrimination principle *vis-à-vis* "care" in IHL, given its fuller development. This is also a core obligation

---

187 *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, 12 August 1949, 75 UNTS 31, at art 12 (entered into force 21 October 1950) [GC I].

188 ICRC, *First GC Commentary*, s*upra* note 179 at para 1434 (art 12).

189 *Ibid* at para 1435; UNHRC, 'Technical Guidance', *supra* note 36 at para 59.

190 ICRC, *First GC Commentary*, s*upra* note 179 at paras 575-577 (Common art 3).

191 World Medical Association (WMA), "WMA Statement in Times of Armed Conflict and Other Situations of Violence" <wma.net> Accessed 9 October 2023, Principle 5.

192 Amrei Müller, "States' Obligations to Mitigate the Direct and Indirect Health Consequences of Non-International Armed Conflicts: Complementarity of IHL and the Right to Health" (2013) 95 Intl Rev Red Cross 129 at 145.

and, as mentioned, requires access to services such as emergency obstetrics care. Additionally, access to BEmOC and CEmOC may be required as part of the right to life, which is a non-derogable right.[193] Given the specific mention of maternity cases in IHL – and the potential alignment with IHRL- – the inclusion of BEmOC is thus reasonable. Since "care" also involves referrals to special treatment centers, there is also no inherent exclusion of CEmOC. However, resource restraints may still make this impracticable.

Meanwhile, safe abortion as a form of "care" is increasingly addressed in the context of IHL. The need for abortion during armed conflict is similar to situations of peace, arising from unwanted pregnancy as a result of consensual sex or sexual violence, or a threat to the health or life of the woman. However, given the particular context of IHL, access to abortion in this regime has primarily been addressed in relation to sexual violence rather than maternal health more broadly. Rape is explicitly and implicitly prohibited in the Geneva Conventions,[194] rules which also constitute CIL.[195] In certain commentaries oo the GCs and the APs, it is argued that rape victims can be included in the category of the "wounded and sick".[196] There is thus room to argue that abortion is a form of required medical care.[197] Non-discrimination in health care is a guiding principle also in this regard. Given that rape may be perpetrated through different *actus rei*, for example, through intercourse or the use of objects, such as the barrel of a gun or a bottle, care should be guaranteed regardless of the type of harm. As noted by the UN Secretary-General, conflict-related sexual violence frequently results in serious health problems for victims, including genital, vaginal and/or anal or other bodily injury,[198] as well as unwanted pregnancy. Remedies should accordingly in-

---

193 However, lawful acts of war affecting this right are acceptable. *See*, for example, ECHR, *supra* note 145, art 15.

194 GC IV, *supra* note 173, art 27; AP I, *supra* note 173, art 76; AP II, *supra* note 171, art 4 (2)(e). It is also considered to fall within the scope of Common Art. 3 of the GCs; GC IV, *supra* note 173, art 147 and GC III, *supra* note 188, art 14.

195 *See* Rule 93 in Henckaerts & Doswald-Beck, *supra* note 76 at 323.

196 Bellal, *supra* note 177, ss B(III)–(IV).

197 *Ibid* at para 33.

198 UNSG, "Guidance Note of the Secretary-General: Reparations for Conflict-Related Sexual Violence" (2014) <unwomen.org> Accessed 15 June 2023 at 12 [UNSG, "Reparations for Conflict-Related Sexual Violence"]. See also *Resolution 2106*, UNSC, 2013, UN Doc S/RES/2106 SC Res 2106 at para 19;

clude access to such medical treatments as fistula surgery and safe abortion services.[199]

Several UN Security Council (UNSC) resolutions emphasize the link between IHRL and IHL on this matter. [200] For example, UNSC Resolution 2467 (2019) refers to CEDAW General Recommendation No. 30.[201] It observes that the disproportionate impact of sexual violence in armed conflict and post-conflict situations on women and girls is exacerbated by, *inter alia*, the lack of available health services for survivors. As such, it calls upon Member States "to ensure that survivors of sexual and gender-based violence in conflict in the respective countries receive the care required by their specific needs and without any discrimination,, thus reaffirming their obligations under CEDAW.[202] This includes care for women who become pregnant as a result of sexual violence.[203] The language of the resolution was controversial and several states pushed for the removal of explicit references to sexual and reproductive health.[204] The resolutions do not in fact concretise *which* services must be ensured. However, given the references to CEDAW, the resolutions should be interpreted in line with CEDAW Committee general recommendations, which oblige states to ensure safe abortion in such circumstances. In reports on Women, Peace and Security, the UN Secretary-General has also noted the need for access to…"… services for safe termination of pregnancies resulting from rape, without discrimina-

---

Resolution 2122, UNSC, 2013, UN Doc S/RES/2122 SC Res 2122 at 2 [UNSC Res 2122].

199 UNSG, "Reparations for Conflict-Related Sexual Violence", *supra* note 200 at 13.

200 UNSC Res 2467, *supra* note 91 at preamble; UNSC Res 1820, *supra* note 48 at preamble and UNSC Res 2122, *supra* note 200 at 2.

201 UNSC Resolution 2467, *supra* note 91 at preamble.

202 *Ibid* at para 16(a). See also CEDAW, "General Recommendation No 30", *supra* note 49 at para 26.

203 UNSC Res 2467, *supra* note 91 at para 18

204 China & Russia abstained while the US threatened to veto. See Christine Chinkin & Madeleine Rees, *Commentary on Security Council Resolution 2467: Continued State Obligation and Civil Society Action on Sexual Violence in Conflict* (London: Centre for Women Peace and Security, London School of Economics and Political Science, 2019) online: <www.un.org> [https://perma.cc/7UGD-UUE6].

tion and in accordance with international human rights and humanitarian law."[205]

IHL also ensures access to care for medical conditions not linked to the conflict. The connection between abortion and maternal mortality has been acknowledged, but to a lesser extent. For example, the European Parliament has noted that unsafe abortion is one of the leading causes of maternal mortality in humanitarian contexts and that states must ensure access to legal and safe abortion, antenatal care, skilled assistance during childbirth and emergency obstetrics.[206] This interpretation of "care" can be further developed through applying IHL in light of IHRL, with the caveat that IHRL – as viewed-– does not offer an altogether consistent approach.

It should also be noted that, in addition to receiving care, the wounded and sick must be treated humanely, which is an obligation of result.[207] This is broader than "care" and prohibits acts or omissions that cause mental or physical suffering. Consideration should be taken of women's particular needs in interpreting the concept.[208] There is also a general prohibition on cruel, inhuman or degrading treatment, extending to persons beyond the wounded and sick.[209] IHRL is also considered of importance in concretizing these concepts, given its continuous development.[210] As mentioned,

---

205 *Report of the Secretary-General: Women and Peace and Security*, UNSC, 2013, UN Doc S/2013/525 at para 72(a).

206 *See* EU, *Resolution 2016/2662(RSP) of the European Parliament of 28 April 2016 on attacks on hospitals and schools as violations of international humanitarian law* [2016] OJ C 66/17 at paraL [EU Res 2016/2662]; EU, Resolution *2015/2520(RSP) of the European Parliament of 30 April 2015 on the situation in Nigeria* [2016] OJ C 346/15 at para 15; EU, *Resolution (2022/2633(RSP)) of the European Parliament of 5 May 2022 on the impact of the war against Ukraine on women* [2022] OJ C 465/15 at paras T, 9.

207 ICRC, *First GC Commentary*, s*upra* note 179 at para 1373.

208 *Ibid* at para 553 (art 3); ICRC, *Commentary on the Third Geneva Convention* (Cambridge: Cambridge University Press, 2021), at para 587 online: <ihl-databases.icrc.org> [https://perma.cc/SNL2-VZC5].

209 Common Art. 3 of the GCs; GC IV, *supra* note 173, art 32; AP I, *supra* note 173, art 75; AP II, *supra* note 171, art 4 (2).

210 Giacca, *supra* note 174 at 799; Henckaerts & Doswald-Beck, *supra* note 76 at 308; Manfred Nowak & Ralph Janik, "Torture, Cruel, Inhuman, or Degrading Treatment or Punishment" in Andrew Clapham et al, eds, *The 1949 Geneva*

not allowing access to safe abortion has, under specific circumstances, been considered a form of inhuman or degrading treatment by various IHRL bodies.[211]

C. Ensuring health care infrastructure

In terms of health care infrastructure, parties to the conflict must take the preparatory and organizational steps that can reasonably be expected of them when the conflict appears imminent and inevitable, to ensure that all wounded and sick persons are cared for.[212] As noted, a core obligation of the ICESCR is to ensure "equitable" distribution of health care facilities. Nevertheless, preparation does not equal the establishment of health care infrastructure from the ground – which is a part of IHRL – but planning and securing goods and services, for example, in view of upsurges in trauma surgery.[213] With the heightened risk of obstetric emergencies and unwanted pregnancies in armed conflicts – and the inclusion of reproductive health being part of "care"-– securing means to ensure access to EmOC and safe abortion should be part of such preparatory obligations.

Similar to IHRL, the obligation to provide care is not absolute but rather one of means, evident in the qualification "to the fullest extent practicable.. This involves both practical factors and resources, contextually assessed. Measures required are thus relative to the availability of medical personnel and equipment as well as the feasibility of such measures in the midst of

---

Conventions: A Commentary (Oxford: Oxford University Press, 2015) at 320-322.

211 In order to more assertively affirm a right to abortion in relation to these provisions, calls have been made for the specific mention of access to reproductive health services in the forthcoming ICRC commentary on Geneva Convention IV. See Christina Zampas et al, "Interpreting International Humanitarian Law to Guarantee Abortion and Other Sexual and Reproductive Health Services in Armed Conflict" (2024) 26:1 Health & Hum Rts 31 at 33-34.

212 ICRC, *First GC Commentary*, s*upra* note 179 at paras 1389-1390 (art12).

213 *See* Pavignani et al, *supra* note 55 at 49 in terms of needs that may arise in armed conflict and Carlos Ferreira & Mariana Correia, 'Surgical frontiers in war zones: perspectives and challenges of a humanitarian surgeon in conflict environments.' Trauma Surg Acute Care Open. 2024 May 23;9(1) at 2, on wartime surgery.

hostilities.[214] It may not be viable to provide the same standards of care in the battlefield as in a medical facility, in terms of equipment and the medical training of persons at the scene.[215] Security conditions are also a factor.[216] Military necessity may, for example, involve the control of medical transports at checkpoints. This would need to be balanced against humanitarian considerations, such as the avoidance of unnecessary delays. The economic resources of the parties to the conflict is also an aspect, although a minimum standard of care must be ensured by all.[217] Arguably, this can be seen as aligned with the duty in the ICESCR to allocate the maximum extent of available resources.[218] Practically, Whether the party is a state or non-state actor is a facto..[219] The resources and capabilities of armed groups are typically not as extensive as those of states. At the same time, if a party to the conflict is unable to ensure care for the wounded or sick, it must permit the ICRC or other impartial humanitarian organisations to provide it.[220] A range of actors may thus be involved.

While practical concerns affect the obligations of parties to the conflict, certain provisions require specific medical services for women. For instance, in relation to prisoners of war, such services must involve a range of "...expertise and skills in dealing with both male and female patients"[221] and "…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....[222] As mentioned, retrogressive measures undermining sexual and reproduct-

---

214 ICRC, *Commentary on the Additional Protocols*, *supra* note 176 at para 451; AP I, *supra* note 173 art 10; ICRC, *First GC Commentary*, s*upra* note 179 at para 1382 (Art. 12).

215 ICRC, *Commentary on the Additional Protocols supra* note 176 at para 451; AP I, *supra* note 173, art 10.

216 ICRC, *First GC Commentary*, s*upra* note 179 at para 1384 (art 12).

217 *Ibid* at para 1391.

218 Giacca, *supra* note 174 at 792.

219 *Ibid* at 802-803.

220 Henckaerts & Doswald-Beck, *supra* note 76 at 402.

221 ICRC, *Commentary on the Third Geneva Convention*, *supra* note 202 at para 1685.

222 *Ibid* at para 2230.

ive health are also generally not accepted under IHRL during periods of resource restraints or as punitive measures during conflict.

For the purpose of aiding the wounded and sick, IHL regulates the safe delivery of medical services and provides protection of medical activities,[223] medical personnel,[224] medical units,[225] and transports used exclusively for medical purposes.[226] These rules are generally considered *lex specialis* in relation to IHRL, given their specificity, and have,informed the interpretation of certain aspects of the right to health in IHRL.[227] The protection of medical units include protection of civilian hospitals organized to care for the wounded and sick as well as maternity cases.[228] The passage of medical transports carrying the wounded and sick or health care personnel must not be arbitrarily denied or restricted.[229] The protection of the delivery of medical supplies and resources to medical units, such as water and electricity, is also included.[230] As noted by the ICRC, the rules on treating the wounded and sick cannot be fulfilled unless the necessary supplies are in place.[231] This is essential also in relation to reproductive health care. For example, the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings places much focus on necessary processes to ensure reproductive health supply chains.[232]

---

223 GC I, *supra* note 189, art 18; AP I, *supra* note 173 art 16; AP II, *supra* note 171, art 10.

224 GC I, *supra* note 189, arts 24–26; arts 36- 37 GC II (n); GC III, *supra* note 188, art 33; AP I, *supra* note 173, art 15; AP II, *supra* note 171, art 9.

225 GC I, *supra* note 189, art 19; GC IV, *supra* note 173, art 18; AP I, *supra* note 173, art 12; AP II, *supra* note 171, art 11.

226 GC I, *supra* note 189, art 35; GC IV, *supra* note 173, art 21; AP I, *supra* note 173, art 21; AP II, *supra* note 171, art 11.

227 Breitegger, *supra* note 144 at 90.

228 See definition in AP I, *supra* note 173, art 8 (e).

229 See Rule 29 in Henckaerts & Doswald-Beck, *supra* note 76 at 98.

230 ICRC, First GC Commentary, s*upra* note 179 at para 1807 (art 19).

231 *Ibid*.

232 IAWG, *Inter-Agency Field Manual, supra* note 25 at 4.

Several UNSC Resolutions have specifically condemned the increasing attacks on health care facilities and personnel, noting that such undermine efforts to maintain international peace and security by producing long-term consequences for health care systems and thus civilian populations.[233] The European Parliament has also denoted attacks on hospitals as "grave breaches" of the Geneva Conventions and war crimes in the Rome Statute,[234] noting the deliberate targeting in recent armed conflicts, including in Afghanistan, Yemen, and Syria.[235]

Furthermore, the free passage of humanitarian assistance is regulated in IHL, including consignment of certain objects necessary for the survival of the civilian population.[236] This involves medical supplies, food, clothing, and other essential goods. The APs hold that consent is required by concerned parties in order for impartial humanitarian relief schemes to be carried out on their territory,. However, it is now considered CIL to allow unimpeded passage of such relief for civilians in need, with consent not to be arbitrarily withheld.[237] Several UN Security Council resolutions have consequently called for the free passage of humanitarian assistance, including medical and surgical supplies.[238] Impeding humanitarian assistance may have direct consequences for reproductive rights, given that it increasingly involves the distribution of post-rape kits; including emergency contraception and medical supplies for abortion and post-abortion care.[239] while maternal health care and the protection of the medical mission is explicitly regulated in IHL, further concretisation of the forms of care and corresponding infrastructure

---

233 See e.g. *Resolution 2286 (2016)*, UNSC, 2016, UN Doc S/RES/2286 SC Res 2286 at para 1; *Resolution 1998*, UNSC, 2011, UN Doc S/RES/1998 SC Res 1998 at para 1.

234 EU Res 2016/2662 *supra* note 208 at paras A, I, R(3).

235 *Ibid* at para A.

236 GC IV, *supra* note 173, arts 23, 30, 55; AP I, *supra* note 173, arts 69–70; AP II, *supra* note 171, art 18. *See also* Rule 55 in Henckaerts & Doswald-Beck, *supra* note 76 at 193.

237 Henckaerts & Doswald-Beck, *supra* note 76 at 193, 197.

238 *Resolution 2165*, UNSC, 2014, UN Doc S/RES/2165 SC Res 2165 at para 2; *Resolution 2191*, UNSC, 2014, UN Doc S/RES/2191 Res 2191 at 2–3.

239 Liv Tonnessen, *Women's Right to Abortion After Rape in Sudan*, CMI Insight April 2015 No 02 (Bergen, Norway: Chr. Michelsen Institute, 2015) at 1-2, online: <cmi.no> [https://perma.cc/8KN2-B9G7].

is required aligned with IHRL – would strengthen protection. While access to safe abortion is increasingly addressed as a form of "care", this is mainly in relation to sexual violence and not maternal health in general. Meanwhile, emergency obstetrics care has received little attention. Considering the link between armed conflict and maternal mortality, more concrete obligations to ensure such forms of care in preparation of impending conflict ought to be affirmed, in order to fully adopt a differentiated approach.

V. International Criminal Law (ICL)

ICL overlaps with IHL and IHRL in that international crimes include war crimes and certain grave violations of IHRL, such as the prohibition of torture and genocide. IHRL and IHL are also specified as sources in the interpretation of crimes in the Rome Statute.[240] In contrast to IHRL and IHL, ICL does not aim to establish a broad protection regime, beyond the preventive effect of prosecution and the restorative capacity of reparations. While the deterring effect of ICL has been questioned at both a general level and on matters of public health,[241] this area of law nevertheless fills an accountability gap through the regulation of individual criminal liabilit, and adds an additional dimension to the systemic approach to maternal health.

Acts affecting access to health care may be international crimes, if conducted under specific circumstances. "Deliberately inflicting on the group conditions of life calculated to bring about [the] physical destruction [of a population] in whole or in part", involving specifically protected social groups, is a form of genocide.[242] This may involve the deprivation of medicine and access to health care, such as the reduction of essential medical services below minimum requirements. Although sex or gender are not listed as protected characteristics *per se*, women of a particular ethnicity, for example, may be targeted. Severe restrictions of medicine and medical care

---

240 *Rome Statute of the International Criminal Court*, 17 July 1998, 2187 UNTS 3 at art 21(3) [*Rome Statute*].

241 David P. Fidler, "Criminal Law and Global Health Governance" in A.M. Viens et al, eds, *Criminal Law, Philosophy and Public Health Practice* (Cambridge: Cambridge University Press, 2013) 237 at 249.

242 *Rome Statute*, *supra* note 244 at art 6(c). See also *Prosecutor v Clément Kayishema & Obed Ruzindana*, ICTR-95-1-T, aff'd ICTR-95-1-A, Judgment (21 May 1999) at paras 115-116 (International Criminal Tribunal for Rwanda, Trial Chamber II) online: <refworld.org> [perma.cc/SDB2-8U32].

can also be a crime against humanity, if in the context of a widespread or systematic attack on civilians. This includes extermination and persecution, the latter which is clearly linked to standards in IHRL.[243] Meanwhile, the war crimes provision – similar to IHL-– protects medical units, transport and personnel.[244] Depriving civilians of medical care in detention has also been considered cruel treatment by the International Criminal Tribunal for the Former Yugoslavia (ICTY).[245] As noted above, IHRL has a decisive influence on the concept of inhuman treatment in IHL. However, ICL is not as extensive as IHL in ensuring medical care to the wounded and sick, nor is there specific protection of maternity cases. Crimes involving maternal health care will thus seldom arise and most likely involve incidents of targeted attacks on health care infrastructure.

Meanwhile, rape can be a form of genocide, crime against humanity, or war crime in certain contexts, and forced pregnancy a crime against humanity or war crime.[246] In fact, the Office of the Prosecutor (OTP) of the International Criminal Court (ICC) has,denoted crimes affecting the reproductive

---

243 *Rome Statute*, *supra* note 244 at arts 7(b), 7(h) which involves the severe deprivation of human rights on the basis of a particular group characteristic, including gender. See also *Prosecutor v Nikolic*, IT-94-2-S, aff'd IT-94-2-A, Sentencing Judgment (18 December 2003) at para 69 (International Criminal Tribunal for the Former Yugoslavia, Trial Chamber II), online: <refworld.org> [perma.cc/YP79-M4GF].

244 *Rome Statute*, *supra* note 244 at arts 8(2)(b)(ix), (xxiv), 8(2) (e)(ii), (iv).

245 *Prosecutor v Milorad Krnojelac*, IT-97-25-T, rev'd in part IT-97-25-A, Judgment (15 March 2002) at para 141 (International Criminal Tribunal for the Former Yugoslavia, Trial Chamber II), online: <refworld.org> [perma.cc/L7RX-7ZNB]; *Prosecutor v Zejnil Delalic et al*, IT-96-21-T, rev'd in part IT-96-21-A, Judgment (16 November 1998) at paras 1101-1105 (International Criminal Tribunal for the Former Yugoslavia, Trial Chamber), online: <refworld.org> [perma.cc/KH7S-3D7C]; *Prosecutor v Mile Mrkšić et al*, IT-95-13/1-T, rev'd in part IT-95-13/1-A, Judgment (27 September 2007) at para 517 (International Criminal Tribunal for the Former Yugoslavia, Trial Chamber II), online: <refworld.org> [perma.cc/CHK8-2B59].

246 *Rome Statute*, *supra* note 244. Rape as genocide: art 6(b) (see Elements of Crimes, ICC fn 3, at 2) and art 6(d) (see International Criminal Court, The Office of the Prosecutor, Policy on Gender-Based Crimes: Crimes Involving Sexual, Reproductive and other Gender-Based Violence (The Hague: ICC Office of the Prosecutor, 2023 at para 37 [The Office of the Prosecutor, ICC]); as a crime against humanity: art 7(1)(g); as a war crime: arts 8(2)(b)(xxii) and 8(2)(e)(vi). Also arts 8(2)(a)(ii), 8(2)(b)(xxi) & 8(2)(c) (ii) are applicable. Forced

autonomy of individuals as "reproductive violence,, including the denial of essential reproductive health care.[247] This has consequences for maternal health care as a remedy.

The availability of maternal health care-– in terms of infrastructure and services offered-– may be addressed in the reparations phase, for example, by the ICC. The ICC has held that the concept of harm includes both physical and psychological injury and must be linked to the crimes for which the accused was convicted.[248] Nevertheless, in applying the 'proximate cause' standard, reparations are not limited to'"direct harm or immediate effects..[249] Reparations may in turn be both individual and collective and involve, for example, "restitution, compensation, rehabilitation,, or symbolism.[250] It thus also allows for transformative reparations that advance gender equality.[251] The OTP specifically promotes a gender-inclusive approach to reparations, taking into account structural gender imbalances and differentiated harm based on gender.[252]

---

pregnancy as a crime against humanity: art 7(1)(g) and as a war crime: arts 8(2)(b)(xxii), 8(2)(e)(vi)).

247 The Office of the Prosecutor, ICC *supra note* 250 at para 37, online: <icc-cpi.int> [perma.cc/MB46-DDBT].

248 *Prosecutor v Thomas Lubanga Dyilo*, ICC-01/04-01/06 A A 2 A 3, Judgment on the Appeals against the Decision Establishing the Principles and Procedures to be Applied to Reparations of 7 August 2012 (3 March 2015) at para 191 (International Criminal Court, Appeals Chamber) online: <icc-cpi.int> [perma.cc/5ZXD-Y5TX].

249 *Prosecutor v Thomas Lubanga Dyilo*, ICC-01/04-01/06, Decision Establishing the Principles and Procedures to be Applied to Reparations (7 August 2012) at para 249 (International Criminal Court, Trial Chamber I) online: <icc-cpi.int> [perma.cc/D38K-RJ9G] [*Dyilo*].

250 *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*, UNGA, 60th Sess, UN Doc A/RES/60/147 (2006) GA Res 60/147 at para 18.

251 The Office of the Prosecutor, ICC, *supra* note 250 at para 143.

252 *Ibid*.

Solely five cases before the ICC have proceeded to the reparations phase, with one involving sexual violence and attacks on health care.[253] The Trial Chamber (TC) in the reparations order in *Prosecutor v Ntaganda* referenced the OTP policy on gender-inclusivity.[254] It concluded that victims of sexual violence suffered both psychological and physical harm, including STDs, pregnancy and damage to genitals.[255] While the Trust Fund for Victims (TFV) specified that reparations should include treatment of gynecological pathologies,[256] the TC summarily awarded physical and psychological rehabilitation, in addition to individual standardized amounts and collective reparations.[257] Access to abortion services was, however, not mentioned. In terms of the damage to the health center in the town, the Chamber found that the attack had a severe impact on the welfare and lives of patients present at the center at the time, as well as the civilian population in general.[258] In considering reparations, the TC took note of the cost of repairing the health center, equipment, essential medicines, hiring skilled personnel and general maintenance.[259]

---

253 *Prosecutor v Germain Katanga*, ICC-01/04-01/07, rev'd in part ICC-01/04-01/07 A3 A4 A5, Order for Reparations (24 March 2017), (International Criminal Court, Trial Chamber II) online: <icc-cpi.int> [perma.cc/9SPQ-ZC85]; *Prosecutor v Ahmad Al Faqi Al Mahdi*, ICC-01/12-01/15, rev'd in part ICC-01/12-01/15 A, Reparations Order (17 August 2017), (International Criminal Court, Trial Chamber VIII) online: <icc-cpi.int> [perma.cc/EUH7-54X5]; *Dyilo, supra* note 244; *Prosecutor v Bosco Ntaganda*, ICC-01/04-02/06, rev'd in part ICC-01/04-02/06 A4-A5, Reparations Order (8 March 2021), (International Criminal Court, Trial Chamber VI) online: <icc-cpi.int> [perma.cc/44MP-KEUC], [*Ntaganda*]; *Prosecutor v Dominic Ongwen*, ICC-02/04-01/15, Order for Submissions on Reparations (6 May 2021), (International Criminal Court, Trial Chamber IX) online: <icc-cpi.int> [perma.cc/2NLV-UEM2].

254 *Ntaganda*, *supra* note 8257 at paras 60–61.

255 *Ibid* at paras 169–170, 174.

256 *Prosecutor v Bosco Ntaganda*, ICC-01/04-02/06-2732, Public Redacted Version of the Annex A (17 December 2021) at para 165 (International Criminal Court, Trial Chamber VI), online: <icc-cpi.int> [perma.cc/Y2LU-9YX7].

257 *Ntaganda*, *supra* note 8257 at para 236.

258 *Ibid* at para 158.

259 *Ibid* at para 242.

In *Prosecutor v Jean-Pierre Bemba*, submissions and expert reports were prepared for reparations proceedings. However, as he was acquitted on appeal, the proceedings were halted. Nevertheless, the submissions highlight the potential interplay between IHRL and ICL in ensuring effective and gender-sensitive reparations in relation to sexual violence. The CESCR General Comment on the right to health and the CEDAW Committee General Recommendation on women in conflict were mentioned as guidance in the expert report on recommendations for reparations.[260] The report noted common physical injuries from rape, including damage to the reproductive system, the contraction of STDs, and unwanted pregnancy.[261] Such physical harm is exacerbated in situations where there is a lack of accessible, affordable, adequate, available, and quality health care to victims.[262] In the Central African Republic, victims of rape had to pay for their own medical care, which was also subpar in terms of hygiene and treatment of victims.[263] The expert report argued that this did not fulfil the criteria of the right to health in the ICESCR.[264] While noting that women were unable to obtain abortions under domestic law, access to such service was not mentioned as a form of reparation.[265]

Although violations involving health care have not been a prominent aspect of prosecutorial practices nor in reparations proceedings so far, there is thus room for recognizing such types of harm also within ICL, while not as extensively as in IHRL and IHL. The purposefully narrow definitions of the crimes – setting it apart from broader provisions in IHRL and protection regimes in IHL – mean that this area of PIL may only lead to limited interventions relating to maternal health care. While IHRL and IHL may inform such crimes as inhuman treatment, persecution, and targeting of the medical mission to include aspects of maternal health care, gendered means of perpetrating international crimes, as well as their gendered effects must be

---

260 *Prosecutor v Jean-Pierre Bemba*, ICC-01/05-01/08-3575-Conf-Exp-Anx-Corr2, Annex, 28 November 2017 (20 November 2017) at para 100 (International Criminal Court, Trial Chamber III), online:<icc-cpi.int> [perma.cc/CXG4-4FTJ], [*Bemba*].

261 *Ibid* at paras 121–122.

262 *Ibid* at para 123.

263 *Ibid* at para 124–125.

264 *Ibid* at para 125.

265 *Ibid* at para 117.

considered. This includes the weaponization of health care and reproductive violence, such as restrictions on reproductive health care.

VI. Conclusion

As noted, the vast majority of maternal deaths are within the capacity of states to prevent. Excessive levels of maternal mortality can be traced to failures to ensure the underlying determinants of health, as well as shortcomings in domestic laws, state budgeting, and health care infrastructure. This in turn stems from a lack of prioritization of women's health and conservative approaches to female autonomy and sexuality. Similar to other social institutions, health care systems thus reflect gendered power structures.

In view of the gendered causes of maternal mortality and the gender-specific forms of health care required; gender equality must be a guiding principle for standard setting in international law. However, public international law also mirrors and enforces patterns of gender inequality, evident in the tentative approach to maternal health care. It has been argued that failures to ensure the right to health globally is not due to weaknesses in the international legal framework but rather the lack of implementation of existing provisions in, for instance, IHL and IHRL.[266] This may certainly be the main challenge. However, it is clear that regulatory gaps also exist in relation to the protection of maternal health care. Certain gaps – such as the lack of regulation of certain services and inadequate obligations – exist within the specific areas of law. Other gaps arise between areas of law – through fragmentation – and are thus connected to the material, temporal, and jurisdictional boundaries of regimes.

As viewed, IHRL, IHL and ICL to varying degrees address maternal health care, either in the form of rights or as part of prohibitions on certain conduct affecting access to health care. This entails that certain minimum standards must be guaranteed at all times and during all circumstances. A shift is thus noticeable, from viewing maternal mortality as beyond human control to addressing it as preventable. Maternal health care has also migrated from being construed as solely a development- or policy issue to acknowledging individuals as rights-holders.

---

[266] ICRC, "International Humanitarian Law and the Challenges of Contemporary Armed Conflicts" (2007) 89: 867 Intl Rev Red Cross 719 at 719, 721; *UNHR, Preventable Maternal Mortality and Morbidity and Human Rights, supra* note 4 at para 61.

Largely, IHRL and IHL rules are complementary in terms of health care. Although armed conflict in many ways adversely affects both the short-term and long-term health of individuals, IHL primarily involves the direct health consequences of conflicts, such as mitigating attacks and treating the wounded in hostilities. Meanwhile, IHRL sets up broader obligations to establish both primary and comprehensive health care systems, including facilities, goods, services and personnel of a certain standard. This allows for greater possibilities to alleviate the indirect health consequences of armed conflicts, such as the increased risks of maternal mortality and morbidity. IHRL also complements IHL in addressing such indirect health effects of hostilities as mass-emigration of doctors, closings of health care facilities and the interruption or termination of preventive health care services. Certain rules and principles relevant to the right to health are similar in these regimes, particularly involving obligations to respect, such as adhering to medical neutrality and the non-obstruction of humanitarian aid. Protection of the wounded and sick is required, as is a minimum level of care. Beyond this, certain differences, though not necessarily conflicts, between rules arise.

IHRL delineates AAAQ standards for health care, with specific requirements for maternal health. The least controversial aspect of the right to maternal health has been to affirm access to primary health care, including ante-natal care. As primary health care is not defined, it becomes a vacuous obligation. Providing emergency obstetrics may be costly-– at least CEmOC - and an unwillingness to place encumbering economic obligations on states can be noted, with such care generally subject to progressive implementation and relative to state resources. A complex patchwork of obligations appears. Ensuring access to emergency obstetrics care is an obligation for states within the right to health. While BEmOC often is part of primary health care-– which is a core obligation – this is not explicitly required according to the CESCR and the CEDAW Committee. It is rather categorized as being of equal importance. CEmOC clearly falls outside minimum standards in relation to these central treaties. At the same time, regional human rights law courts and UN treaty bodies alike have affirmed that access to effective and affordable EmOC may, under certain circumstances, be encompassed by the right to life. This concerns both BEmOC and CEmOC. Denying such care may also be a form of sex discrimination in relation to the right to health, and even a form of gender-based violence. Nevertheless, states retain certain discretion in terms of health care infrastructure.

As for the content of obligations, the general framework of the right to health requires that stats parties ensure essential determinants for preventing obstetric emergencies, such as education, reduction of poverty and access to food and water. Regional human rights law courts and UN bodies have also

cumulatively developed certain standards for emergency obstetrics,,such as skilled personnel, swift referral systems, and equitable distribution of EmOC facilities. IHRL accordingly takes a holistic approach, recognizing a range of factors that undermine health. While technical guidelines and indicators by international organizations provide more specific standards in terms of quantity and quality of care, these are generally not connected to specific treaty obligations but may aid states in concretizing obligations and have been referenced by, for example, the CESCR.

From the perspective of effective standards for eliminating maternal mortality, current issues *vis-à-vis* emergency obstetrics care in IHRL thus concern the status of obligations – as non-core – as well as their abstract formulation, that is, an overly broad discretion in implementation for such essential care. Broad standards often lead to gendered interpretations by states, and explicit recognition of differentiated care is necessary. BEmOC does not require extensive resources as it can be performed through primary health care and such care alone significantly reduces maternal mortality. Meanwhile, CEmOC is not only more effective in relation to certain obstetric emergencies but also necessary in relation to particular medical conditions. In view of the significance of access to EmOC in preventing maternal mortality, such services must be affirmed by IHRL bodies as fundamental aspects of the right to health, life and humane treatment. In relation to the right to health, the CESCR should more assertively affirm that EmOC is encompassed by core obligations. This would firmly place it beyond the realm of states' discretion in the allocation of resources and retrogressive measures.

As for safe abortion, there is broad support in IHRL for ensuring access to victims of rape and in instances of a threat to a woman's health or life. In contrast, access to abortion upon request has not been widely affirmed as a right but is generally a matter of state preference. Here, public morality – involving protection of the foetus - overrides the interests of the pregnant woman. While the CESCR and the CEDAW Committee increasingly address access to safe abortion as part of the right to maternal health, this approach is rather limited in IHRL. A reframing of the harm is thus necessary in order to avoid narrow interventions. Access to abortion must be considered from the broader perspective of preventing maternal mortality, that is, addressing unsafe abortion as one of the most common causes of obstetric emergencies. This similarly requires the recognition of access to abortion as a core obligation under the right to health – with a view to ensuring *de facto* equality-– and its restriction a form of inhumane treatment and discrimination.

While gender compounds access to health care regardless of context, armed conflict heightens women's vulnerability. Whereas IHRL continues to apply in such situations, IHL provisions offering protection of health care personnel, health care facilities and medical transport are considered *lex specialis* in relation to IHRL, entailing a balancing between humanitarian concerns and military necessity. IHL also offers protection for the wounded and sick, including providing care. While certain requirements of "care" are specified-– such as ensuring medical neutrality-– the form, quantity and quality of health care services are generally abstract. Mention of emergency obstetrics care is largely absent from IHL sources, including in the commentaries to the GCs and APs. Considering that urgent medical assistance to pregnant women is specifically mentioned-– without the medical condition necessarily arising from the conflict-– emergency obstetrics care is, arguably, encompassed in "care.. This may include both BEmOC and CEmOC, since "care" involves both administering care on the spot as well as handing over persons for transport to medical facilities.

Nevertheless, although states must prepare their health care systems to ensure a minimum standard of care to the wounded and sick, such preparations do not involve the establishment of health care infrastructure from the ground. Primary, secondary and tertiary levels of health care should already be in place, through obligations for states parties in IHRL treaties. Preparations must reasonably include ensuring the availability of personnel, services and goods in relation to forms of care essential during armed conflict. In view of the increased risks of obstetric emergencies and unwanted pregnancies during conflict, this may well involve preparations for EmOC and safe abortion. At the same time, qualifiers such as "as far as practicable" indicate a similar pragmatic approach as under the ICESCR. Obligations of care are thus relative to the particular context, considering such aspects as security, access to medical equipment, medical training of personnel and the economic resources of the party concerned. Nonetheless, a lack of medical services is not considered a valid reason for failing to ensure reproductive health care even during armed conflict.

Meanwhile, access to abortion during armed conflict is increasingly addressed in relation to IHL, for example, in UN and European Union (EU) resolutions. Mainly, it is viewed as a remedy in response to rape, with indications that rape victims may be part of the category of "wounded and sick" and abortion a form of "care.. Certain EU resolutions have taken a broader approach, considering access to safe abortion a required form of care *per se*, by linking it to maternal health. The principle of non-discrimination is central in the protection of "maternity cases,, entailing that there should be no distinction of pregnant women on the basis of the reasons for seeking

care. Additionally, the right to humane treatment arguably includes a right to safe abortion. While the framework is thus already in place in IHL to ensure access to EmOC and safe abortion – given its broad frame - the necessary step is thus to concretize and affirm such obligations, for example, in ICRC commentary.

As for ICL, while this area of PIL does not aim to establish a broad protection regime, several crimes encompass the targeting or denial of health care. However, the threshold for international crimes entails that prosecution of restrictions on maternal health care will only arise under very narrow circumstances, such as the systematic and intentional denial of care for specifically protected groups. While orders of reparations are a means of addressing the health-related consequences of international crimes – including ensuring EmOC and safe abortion - this has been subject to limited attention. Not only are prosecutions thus scant with regard to crimes involving health care, but similar gaps as in IHL are reproduced.

In terms of addressing these gaps and inconsistencies, existing rules may be strengthened, *inter alia*, through interpretative means, given the abstract nature of treaty provisions in the three PIL areas. The evolutive treaty interpretation method may be used to establish more robust rights and obligations associated with EmOC and safe abortion. While the object and purpose of IHRL, IHL and ICL differ, a similar core of protecting and/or deterring harm to the health and life of persons is amenable to a gender-sensitive development.

To a certain extent, a harmonized interpretation of rules in IHRL, IHL and ICL - through systemic integration –-may clarify the content of rules and enhance individual protection. While systemic integration in this case mainly relies on soft law sources in IHRL, and thus not necessarily "applicable law,, as noted, such harmonized interpretations are continuously undertaken by a range of international and regional actors.

While IHL is generally considered *lex specialis* in times of armed conflict - given that its norms are tailored to the realities of conflict situations - the content of IHRL is not only more comprehensive in relation to the right to health, but also more detailed through continuous treaty interpretation, for example, by regional courts/commissions and UN bodies. IHRL may thus concretize abstract norms in IHL, if suitable in view of the aim and material limits of the regime. This includes the scope of "care" to the wounded and sick, the prohibition on torture, inhuman or degrading treatment as well as the non-discrimination principle in relation to health, through which an obligation to ensure access to emergency obstetrics and safe abortion

is emerging. The interpretation in IHRL of the prohibition on inhuman or degrading treatment, the non-discrimination principle and such crimes as persecution is also relevant *vis-à-vis* ICL. IHRL may additionally inform the content of reparations in ICL, by ensuring a gender-sensitive approach to the consequences of, for example, sexual violence and restricted access to maternal health care. Arguably, rehabilitative reparations should be consistent with international standards on the right to health and gender equality, including the principles affirmed in CESCR and CEDAW Committee recommendations. Nevertheless, as noted, gaps currently exist also in IHRL in relation to these forms of services and the progressive realization of health care remains the same in both areas. Harmonization does thus not cure the issues that exist in all areas.

Convergence may strengthen protection in more general ways. One area where this is notable is accountability. Harmonization may, for example, ensure consistency in fulfilling the right to health where states have lost control during armed conflict and non-state actors have sliding scale IHRL obligations, with IHRL influencing the interpretation of IHL provisions. With IHRL aiding the interpretation of certain international crimes, it also strengthens individual accountability mechanisms for violations of socio-economic rights. Nevertheless, obligations to fulfil - such as health care infrastructure - are mainly within the domain of states and are primarily regulated through IHRL.

Harmonization is also valuable from a temporal perspective. Armed conflict spurs an increased need for and decreased access to maternal health care, which frequently remains post-conflict. However, the causes of maternal mortality are continual, whether in peacetime, armed conflict or in post-conflict situations. It would thus be valuable to align core obligations on maternal health care to ensure consistent standards regardless of circumstances. This is also reasonable in view of the fact that it is disputed when the application of IHL ends, particularly in NIACs.

While international law inevitably suffers from the tension between its objectives and respecting state sovereignty – evident, for instance, in the construction of abstract norms, broad discretion in state implementation, progressive realization of socio-economic rights and weak enforcement mechanisms – it has the potential to develop meaningful standards on maternal health care. The current legal frameworks in IHRL, IHL and ICL provide platforms through which more vigorous and gender-sensitive regulation can be formed – a necessary development to propel maternal health care beyond realm of domestic policy.