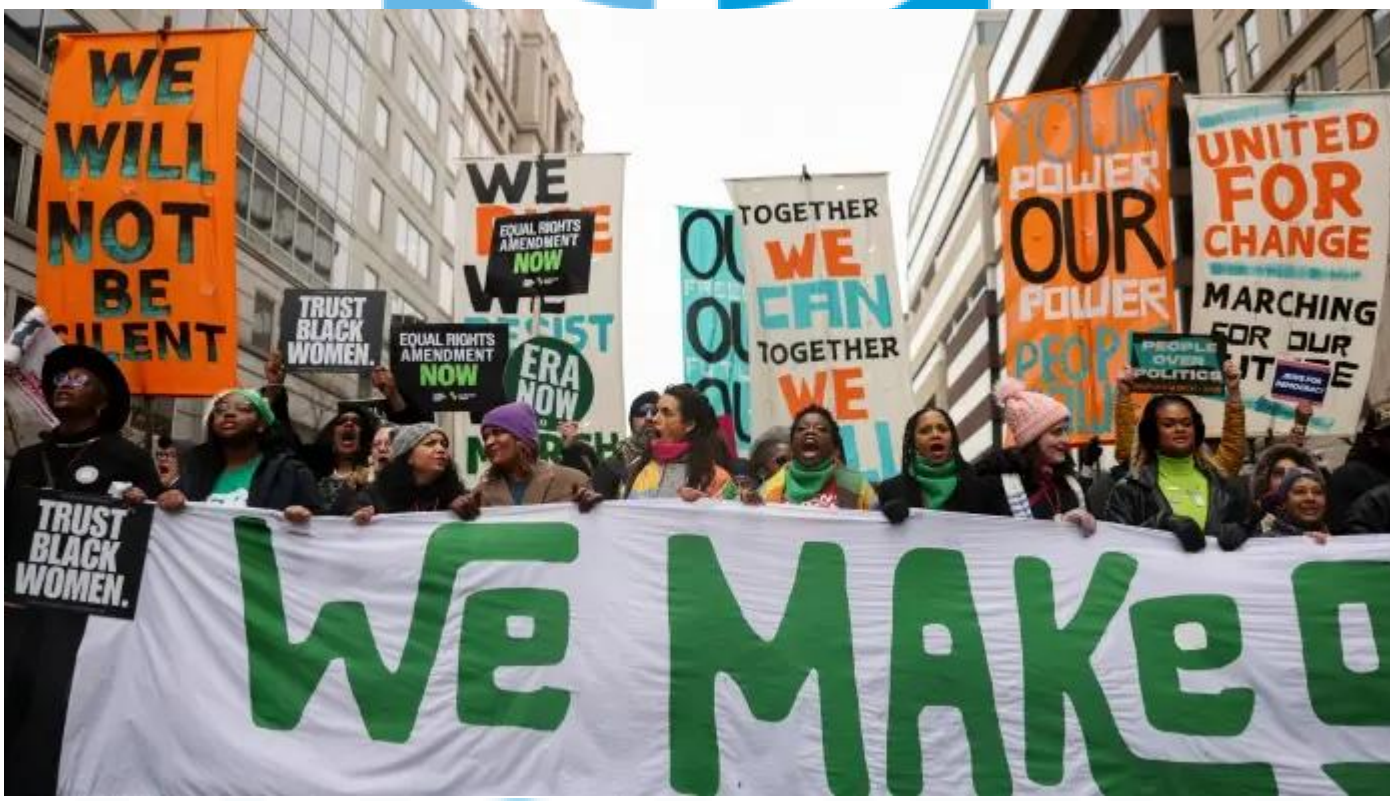
Background Guide

ODM MUN 2025
United Nations Women (UNW)



WOMEN

Agenda- Protecting Women's Rights and Access to Health Services in Conflict Zones and Authoritarian Regime

Contents:

1. Letter from the Executive Board

Greetings Delegates,

It gives us immense pleasure to serve as your Executive Board for the simulation of the UN Women (UNW) at **ODM Model United Nations 2025**. We look forward to an enriching and rewarding experience. The agenda which will be simulated will be: -

"Protecting Women's Rights and Access to Health Services in Conflict Zones and Authoritarian Regime"

Note: UNAUSA ROPs will be followed during the committee.

We are delighted to welcome you to this crucial committee simulation, one that seeks to address a global issue of immense significance. As the Executive Board, our goal is to ensure that this experience is both intellectually rewarding and enjoyable. Your dedication, enthusiasm, and willingness to engage will be crucial in shaping the success of this simulation. We hope that you have started your initial, most basic research on the agenda and associated issues from this point on. We must first grasp the Committee's scope and that, while there may be broad discussion on this agenda, council decisions cannot address issues that fall outside the purview of the committee and mandate.

At this stage, we believe that you have begun your initial research on the agenda and the issues related to it. It is essential to develop a clear understanding of the committee's scope, dynamics and mandate before engaging in deeper deliberations. While discussions may be wide-ranging, it is important to remember that committee decisions must remain within its defined jurisdiction.

The study guide that follows has been prepared to help you understand the structure, functions, and working mechanisms of the committee. However, we would like to emphasize that this document is only a guiding framework and should not be treated as your sole source of preparation. While it outlines a possible direction for committee debate, we encourage you to bring fresh insights and alternative approaches to the table. We value creativity, and we hope to see delegates expand beyond the limitations of the guide.

As your Executive Board, we are here only to facilitate the discussion, not to shape its content. Apart from procedural formalities, we will refrain from expressing our own views on substantive matters. The quality of debate will be determined by your contributions, questions, and responses. While we expect delegates to be familiar with the Rules of Procedure, we encourage you not to see them as rigid or inflexible. We are open to suggestions, and if the committee collectively believes that certain modifications can improve the flow of debate, we welcome such feedback and will consider them promptly.

We urge all delegates to use the background guide provided as only the beginning of your research. Meaningful and engaging discussions will arise only when you look beyond the guide and delve into various sources. We hope to see analysis rather than summary, argument rather than repetition. Do not hesitate to present unconventional solutions only if you can defend them effectively, others will engage with them.

Most importantly, we call on every delegate to approach this committee with sincerity, preparation, and a shared commitment to learning. Your participation will shape not only your individual journey but also

the collective experience of your peers. Should you have any questions, concerns, or suggestions, please feel free to reach out to us at any time.

All the Best

Executive Board | UNW

Baisakhi Priyadarshini – Chairperson (baisakhijena123@gmail.com)

– Vice Chairperson

2. Introduction to the Committee

The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) was established in July 2010 by the United Nations General Assembly through Resolution A/RES/64/289. UN Women became operational in January 2011 and serves as the principal UN body dedicated to accelerating progress on gender equality and women's rights worldwide. It was created to address the fragmentation and limited impact of past UN Structures by consolidating four pre-existing bodies: DAW (Division for the Advancement of Women), INSTRAW (International Research and Training Institute for the Advancement of Women), OSAGI (Office of the Special Advisor on Gender Issues), and UNIFEM (United Nations Development Fund for Women).

As laid out in its founding resolution and its strategic plans, the core mission of UN Women is to support intergovernmental bodies such as the Commission on the State of Women (CSW) and the Economic and Social Council (ECOSOC) in their formulation of policies, global standards, and norms; help Member States to implement these standards by providing technical and financial support and to hold the UN system itself accountable for gender mainstreaming across all areas of its work. UN Women's headquarters is in New York City, USA, and it maintains a field of presence in more than 90 countries globally.

UN Women is uniquely mandated by the General Assembly to lead, coordinate, and promote accountability within the UN system for its work on gender equality and women's empowerment. It operates with a hybrid governance structure, reporting both to the General Assembly and ECOSOC, and is overseen by an Executive Board made up of 41 Member States elected by the UN's regional groups. UN Women is indeed through a combination of voluntary contributions from Member States and partners.

Unlike other intergovernmental forums, UN Women functions as both an operational agency and a normative support body. While it does not adopt binding resolutions like the Security Council, nor serve as a full deliberative body like the General Assembly, its policies, frameworks, and recommendations significantly influence regional legislation, UN programming and international treaties pertaining to gender equality. It collaborates closely with numerous global bodies including Office of the High Commissioner of Human Rights (OHCHR), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children's Education Fund (UNICEF) and the Peacebuilding Commission (PBC), among others.

Historically, UN Women has played a central role in the implementation of global normative frameworks such as the Beijing Declaration and Platform o fAction (1995), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the 2030 Agenda for Sustainable Development, particularly SDG 4 on Gender Equality. It has also been instrumental in integrating a gender perspective into post-conflict peacebuilding, humanitarian response, climate action, and economic recovery efforts.

All recommendations or outcome documents emerging from UN Women and its affiliated platforms such as the CSW as non-binding in nature. However, they are crucial in shaping global consensus, mobilizing funding, and guiding national legislation on gender equality.

Mandate of UN Women (UNW)

UN Women is mandated to:

i. Normative Support Function: Assisting intergovernmental bodies, such as the Commission on the Status of Women (CSW) and the General Assembly in formulating global standards and policies on gender equality and women's empowerment.
ii. Operational Support Function: Supporting Member States at their request in implementing international standards and commitments through technical and financial assistance, capacity-building, and programmatic support.
iii. UN System Coordination: Leading and promoting accountability in the UN system's work on gender equality, including monitoring system-wide performance and ensuring effective gender mainstreaming across all UN entities.
iv. Monitoring & Evaluation: Tracking the progress of Member States on the implementation of gender equality commitments, including those outlined in CEDAW, the Beijing Platform for Action, and the 2030 Agenda (SDG 5).
v. Policy Advocacy & Research: Producing data, research, and policy recommendations on key gender-related issues, including women's participation in peace processes, combating gender-based violence, and promoting women's economic empowerment.
vi. Gender Mainstreaming in Peace and Security: Supporting the implementation of the Women, Peace and Security agenda, especially UNSC Resolution 1325 and its subsequent resolutions, by promoting women's leadership and protection in conflict and post-conflict settings.
vii. Global Partnerships and Mobilization: Engaging civil society, the private sector, youth organizations, and other stakeholders to advance gender equality, and advocating for increased investment in gender-responsive policies and initiatives.

3. Overview of the Agenda

This agenda addresses the legal and humanitarian imperative of protecting women's rights and access to health services in settings affected by armed conflict and authoritarian governance. It focuses particularly on the obligations of state and non-state actors under international law, with special attention to how structural discrimination, armed violence, and legal repression intersect to impact women's access to essential health services.

In the context of armed conflict, women are recognized as protected persons under International Humanitarian Law (IHL), including Common Article 3 of the Geneva Conventions and the Additional Protocols, which prohibit violence to life, outrages upon personal dignity, and denial of medical care to those not taking active part in hostilities. IHL, as codified and developed through customary rules and the Geneva Conventions, explicitly prohibits sexual violence, enforced pregnancy, and medical discrimination against women and girls. The principle of non-discrimination embedded in these instruments obliges all parties to a conflict to ensure women's equal access to humanitarian aid and healthcare without adverse distinction. In

authoritarian regimes, legal restrictions and political control often result in systemic suppression of civil liberties, including restrictions on the rights of women to bodily autonomy, privacy, and access to information about reproductive health. Such regimes may also criminalize or limit the work of civil society and healthcare providers, thereby impeding delivery of life-saving services.

The agenda also examines SRHR (Sexual and Reproductive Health and Rights) as a core element of the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights, and as reaffirmed by General Recommendation No. 24 of the Committee on the Elimination of Discrimination against Women. These rights are indivisible from other human rights and require particular safeguards in times of crisis. General Recommendation No. 30 on Women in Conflict Prevention, Conflict and Post-conflict Situations provides a binding interpretative framework for State obligations under CEDAW, affirming that States are responsible not only for their direct actions but also for failing to regulate or prevent rights violations by third parties, including non-state actors and occupying powers. It further clarifies that women's rights under the Convention do not cease during armed conflict or authoritarian transitions, and that extraterritorial obligations may apply, particularly in cases of occupation or cross-border control of healthcare access.

This agenda therefore seeks to assess how intersecting legal regimes; i.e., humanitarian, human rights, and criminal law, can be operationalized to ensure women's substantive equality in health access, dignity, and protection in highly restricted or conflict-affected environments.

4. Legal Risks to Women's Rights under Conflict and Authoritarian Rule

a. Suppression of SRHR under Emergency Derogations (ICCPR Article 4, CEDAW compliance in states of exception)

In situations of armed conflict, political instability, or public emergency, states may invoke legal frameworks that allow for the temporary suspension of certain rights. Article 4 of the International Covenant on Civil and Political Rights (ICCPR) permits such derogations in times of a "public emergency which threatens the life of the nation," provided they meet strict conditions of necessity, proportionality, and non-discrimination. Any derogation must be officially proclaimed, temporary, and subject to international oversight, including notification to the United Nations Secretary-General. However, in practice, the invocation of emergency powers by both authoritarian regimes and conflict-affected governments has often resulted in sweeping and prolonged restrictions on civil liberties and social services, particularly targeting areas related to bodily autonomy and reproductive decision-making.

Sexual and Reproductive Health and Rights (SRHR), while not explicitly named in the ICCPR, are an integral component of the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), and are inseparably linked to rights to privacy, non-discrimination, life, and freedom from torture or cruel, inhuman, or degrading treatment. Under emergency regimes, states have curtailed access to essential SRHR services including prenatal and postnatal care, emergency contraception, abortion services (where legal), and clinical management of rape. These restrictions may be formalized through emergency decrees, military orders, or religious edicts, or may arise from indirect barriers such as movement restrictions, forced displacement, breakdown of supply chains, or the criminalization of healthcare providers.

While the ICCPR permits derogation under limited circumstances, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) does not contain any derogation clause. CEDAW obligations remain binding at all times, including during armed conflict, occupation, and states of emergency. As clarified by General Recommendation No. 30, State parties are responsible for preventing, investigating, and remedying violations of women's rights during conflict and crisis, including those committed by state actors, non-state armed groups, and third parties. States are also required to ensure the availability, accessibility, acceptability, and quality of SRHR services, and must avoid policies that result in de facto or de jure discrimination against women and girls.

Authoritarian regimes frequently exploit emergency powers to enact laws that disproportionately affect women, such as restrictions on access to information, censorship of reproductive health content, or surveillance and criminalization of women's rights defenders and healthcare workers. These measures often lack transparency, are shielded from judicial review, and operate in environments where independent civil society and media oversight are suppressed. The cumulative impact of such policies is to entrench gender inequality, limit accountability for abuses, and deprive women of access to life-saving services at the very moment when vulnerabilities are most acute.

b. Systematic Use of GBV as a Tool of Control or Warfare (Rome Statute, Customary IHL Rule 93)

Gender-based violence (GBV), particularly in the form of sexual violence, has increasingly been recognized as a method of warfare and state repression. In both international and non-international armed conflicts, such acts are not incidental but often strategically deployed to terrorize populations, forcibly displace communities, and destroy social cohesion. The use of GBV in these contexts constitutes a grave breach of international law and engages both individual criminal responsibility and state accountability. Under the Rome Statute of the International Criminal Court (ICC), rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, and other forms of sexual violence can qualify as war crimes under Article 8, crimes against humanity under Article 7, and in some contexts, acts of genocide under Article 6 when committed with the intent to destroy, in whole or in part, a protected group.

Customary International Humanitarian Law, particularly Rule 93 as identified by the International Committee of the Red Cross (ICRC), affirms that rape and other forms of sexual violence are prohibited at all times and in all circumstances. These prohibitions are applicable not only to state forces but also to non-state armed groups and occupying powers, and are binding regardless of whether a state has ratified specific treaties. Violations of this rule engage command responsibility, whereby military or political leaders may be held liable for acts committed by subordinates if they knew or should have known about such conduct and failed to prevent or punish it.

In authoritarian regimes, the risk of state-sanctioned or tolerated GBV is compounded by the absence of judicial independence, suppression of reporting mechanisms, and deliberate targeting of women human rights defenders, protestors, and politically active women. GBV is often used as a method of intimidation during interrogations, in detention facilities, and through state-aligned militias or intelligence services. Victims may face reprisals for reporting abuse, including further violence, arbitrary detention, or social ostracization. The denial of legal remedies and lack of prosecutorial action create an environment of impunity, which is contrary to States' obligations under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and customary human rights norms. Under CEDAW General Recommendation No. 30, States are required to exercise due diligence in preventing, investigating, punishing, and providing reparations for acts of GBV in conflict and crisis settings, including when committed by private actors.

The systematic use of GBV in these contexts thus constitutes both a manifestation of power asymmetry and a violation of peremptory norms of international law. Its prohibition is absolute and non-derogable, and all

States have a responsibility under international law to prevent such acts, prosecute perpetrators, and provide redress to survivors through victim-sensitive and trauma-informed mechanisms.

c. Erosion of Civil Liberties (legal restrictions on NGO activity, expression, and movement affecting service access)

In conflict zones and authoritarian regimes, the erosion of civil liberties significantly impairs women's ability to access health services and exercise fundamental rights. Governments often introduce legal and administrative measures that restrict the functioning of civil society organizations, particularly those focused on women's rights, reproductive health, and gender-based violence. These measures frequently include compulsory registration with vague approval criteria, burdensome financial reporting obligations, limitations on foreign funding, and broad national security laws that allow for arbitrary suspension or criminalization of organizational activity.

In Afghanistan, following the takeover by the Taliban in 2021, authorities issued edicts that prohibited women from working with both national and international non-governmental organizations. As a consequence, women across the country were cut off from access to female medical personnel, which is especially critical in conservative settings where norms severely limit contact between women and male health providers. This led to the disruption of maternal care, contraception services, and basic clinical outreach, directly contravening international humanitarian principles and the right to health as protected under Article 12 of the International Covenant on Economic, Social and Cultural Rights.

Similar patterns can be observed in Egypt, where Law No. 149 of 2019 imposed severe constraints on civil society operations. Women's rights groups working on issues such as legal assistance for survivors of domestic violence or access to sexual health education have reported increased surveillance, intrusive inspections, and arbitrary legal action. These constraints have resulted in the weakening of service delivery networks, especially in underserved areas such as informal settlements and rural regions, thereby increasing the vulnerability of women to rights violations without access to redress or protection.

Freedom of movement is also frequently restricted in these environments, particularly under the guise of public morality, emergency law, or counterterrorism frameworks. In Gaza, for instance, the blockade and associated permit regime have resulted in regular delays or outright denials of travel for women seeking urgent medical treatment outside the territory, including for advanced maternal care or cancer treatment. These restrictions constitute a violation of the principle of medical impartiality under international humanitarian law and obstruct access to essential care in breach of the obligations of occupying powers.

Freedom of expression is suppressed through the use of defamation charges, cybercrime laws, and anti-state activity provisions that silence healthcare workers, women human rights defenders, and journalists. In Saudi Arabia, the arrest and detention of prominent women activists who advocated for basic freedoms, such as the right to drive or the right to access reproductive health information, illustrates how advocacy for women's autonomy is treated as a threat to national security. The use of prolonged detention, forced confessions, and ill-treatment has been widely documented and condemned by UN human rights mechanisms as inconsistent with the state's obligations under the International Covenant on Civil and Political Rights and the Convention on the Elimination of All Forms of Discrimination against Women.

The cumulative effect of these restrictions is the systematic denial of women's ability to participate in public life, access essential services, and claim their rights. These practices reinforce gender-based exclusion and hinder the work of international and local actors seeking to deliver aid or conduct oversight. General Recommendation No. 30 of the CEDAW Committee reaffirms that states retain full legal responsibility to protect and promote women's rights during armed conflict and political repression. This includes ensuring an enabling environment for civil society, protecting freedom of movement and expression, and refraining from practices that have a disproportionate impact on women and girls.

5. Barriers to Health Services Delivery

a. Targeting of Health Infrastructure (Geneva Convention I & IV, UNSC Resolution 2286)

The deliberate or indiscriminate targeting of health infrastructure in conflict zones constitutes a grave breach of International Humanitarian Law and a direct threat to women's health and survival. Under the First and Fourth Geneva Conventions, medical facilities, units, and transports exclusively assigned to medical purposes are granted protected status. Attacks against such facilities are prohibited unless they are being used, outside their humanitarian function, to commit acts harmful to the enemy. This protection is reaffirmed by customary IHL and has been codified in international jurisprudence as binding on both state and non-state actors.

The gendered implications of these violations are profound. When health infrastructure is destroyed or rendered inoperative, women lose access to maternal care, emergency obstetric services, treatment for sexual and gender-based violence, and contraceptive supplies. These facilities often also provide psychosocial support, post-rape clinical management, and access to legal or safe abortion where permitted. The collapse or inaccessibility of such services disproportionately affects pregnant women, women with chronic conditions, and survivors of wartime sexual violence, placing them at significantly elevated risk of preventable mortality and long-term health complications.

UN Security Council Resolution 2286 (2016) specifically condemns attacks on healthcare workers and facilities in armed conflict and calls on all parties to comply fully with their obligations under IHL. Despite this, violations persist with near-total impunity. In Syria, for example, repeated aerial bombardments targeted hospitals in Idlib and Aleppo during the civil war, including several facilities supported by international humanitarian organizations. These attacks not only depleted medical capacity but also deterred healthcare workers from operating in high-risk zones, creating critical gaps in maternal and neonatal care. Similarly, in the Gaza Strip, Israeli airstrikes during multiple military operations have resulted in the destruction or damage of hospitals and UN-run clinics, directly undermining access to antenatal services, contraception, and emergency treatment for injured civilians, including women and girls. Reports from humanitarian agencies confirm that these facilities were clearly marked and notified in advance to military authorities, indicating a disregard for established deconfliction protocols.

In addition to physical attacks, occupation-related restrictions and bureaucratic impediments such as denial of permits for rebuilding or import of medical equipment further prolong service disruption. These structural constraints disproportionately impact women's access to care due to sociocultural limitations on mobility, lack of female medical personnel, and dependence on community health networks that are often dismantled or defunded in conflict situations.

This pattern of targeting and systemic obstruction violates not only Geneva Conventions I and IV but also broader human rights obligations under the International Covenant on Economic, Social and Cultural Rights, which guarantees the right to the highest attainable standard of health without discrimination. As such, the protection of health infrastructure must be treated not solely as a matter of military compliance, but as a fundamental precondition for safeguarding women's rights and bodily autonomy during conflict.

b. Denial of Access to SRHR Services (de facto and de jure restrictions, non-discrimination obligations under ICESCR Article 12)

The denial of access to Sexual and Reproductive Health and Rights (SRHR) services in conflict zones and authoritarian regimes remains a critical barrier to women's physical and mental well-being. This denial often occurs through both de jure restrictions, such as laws that criminalize or restrict reproductive healthcare, and de facto barriers, such as the collapse of health infrastructure, fear of reprisals, or deeply embedded gender norms that inhibit care-seeking behaviour. These restrictions violate international legal obligations under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. General Comment No. 22 of the Committee on Economic, Social and Cultural Rights further affirms that this includes access to a full range of sexual and reproductive health services, including contraception, maternal health, emergency obstetric care, and access to safe abortion where it is not against the law.

In authoritarian regimes, SRHR services are often subject to ideological or political control. For example, in the Islamic Republic of Iran, the introduction of restrictive population policies in 2014 led to the curtailment of access to contraceptives and a ban on the promotion of family planning, which disproportionately impacted women in rural and marginalized communities. Similarly, in Afghanistan under Taliban rule, the imposition of gender-based restrictions has severely limited women's ability to access prenatal care, attend hospitals without a male guardian, or receive treatment from male doctors, effectively reducing access to essential SRHR services for large segments of the female population.

In conflict zones, healthcare systems are often fragmented or targeted, leading to a breakdown in service delivery. During the Syrian conflict, attacks on hospitals and the targeting of healthcare workers created widespread fear among patients and providers, causing pregnant women to avoid institutional births. Reports from Homs and Aleppo indicated that many facilities offering gynecological and obstetric services had shut down entirely, leading to a rise in preventable maternal deaths. The same phenomenon was observed in parts of South Sudan, where civil war has led to the displacement of millions and the virtual collapse of maternal health service delivery in conflict-affected regions.

Furthermore, restrictive policies on aid distribution or arbitrary bureaucratic controls can hinder the import of critical reproductive health supplies. For instance, in Gaza, the blockade and permit regime has been cited by multiple UN agencies as a major impediment to the delivery of menstrual hygiene products, emergency contraception, and trained personnel. These barriers, while not codified into law, functionally deprive women of access to essential care and constitute de facto violations of their health rights.

States and occupying powers have a legal obligation to respect, protect, and fulfill the right to health without discrimination. This includes refraining from obstructing humanitarian access to SRHR services, ensuring the legal and practical availability of such services in both public and private systems, and addressing the underlying social determinants of health, such as gender-based violence, early marriage, and poverty, which are exacerbated in conflict and authoritarian settings. Failure to do so not only contravenes obligations under ICESCR Article 12 but may also constitute gender-based persecution under international criminal law when denial is systematic and intended to suppress or punish specific populations.

c. Collapse of Public Health Systems (supply chain disruption, provider flight, coordination failures)

In conflict zones and authoritarian regimes, the collapse of public health systems represents one of the most significant impediments to the realization of women's right to health, particularly in relation to sexual and reproductive health services. This collapse is typically multifactorial, driven by the destruction of infrastructure, breakdown of essential supply chains, loss or displacement of medical personnel, and the erosion of institutional coordination mechanisms.

Supply chain disruption is a primary feature of systemic collapse. Armed conflict often results in damage to transportation networks, blockades, and insecurity that prevent the delivery of critical supplies such as

contraceptives, antibiotics, blood products, maternal health kits, and equipment for emergency obstetric care. For example, during the conflict in Yemen, reports by the United Nations Population Fund (UNFPA) documented widespread shortages of reproductive health supplies, contributing to increased maternal mortality and preventable complications during childbirth. In such contexts, even when facilities remain structurally intact, their operational capacity is nullified by the absence of essential inputs.

The flight or targeting of healthcare providers further depletes system functionality. Health workers may be internally displaced, subjected to intimidation or violence, or deprived of the resources needed to work safely. In Syria, over 70 percent of the healthcare workforce reportedly left the country or relocated domestically due to threats from state and non-state actors. This led to chronic staff shortages, especially of trained midwives, gynaecologists, and female health professionals who are essential for culturally and legally acceptable service delivery in many regions. In Afghanistan, following the reassertion of Taliban control, women health workers faced increasing restrictions on employment and mobility, compounding the shortage of qualified providers and making it harder for women patients to access care due to gender norms prohibiting treatment by male physicians.

Institutional coordination failures exacerbate these challenges. Fragmented governance, parallel systems of authority, and interference by military or political actors in humanitarian operations obstruct efficient service provision. The Libyan civil conflict, for instance, resulted in competing health ministries and overlapping chains of command, delaying international assistance and impeding data collection critical for needs assessments and response planning. Authoritarian regimes may further obstruct coordination by restricting humanitarian access, censoring information, or criminalizing engagement with foreign NGOs and UN agencies. These measures prevent a unified or evidence-based health response and disrupt the deployment of mobile clinics, the establishment of safe zones for maternal care, or the continuity of care for chronic conditions such as HIV, obstetric fistula, or unsafe abortion complications.

The cumulative impact of these failures disproportionately affects women and girls, who often require time-sensitive and continuous care. The collapse of referral systems, antenatal tracking, emergency evacuation services, and postpartum care mechanisms results in a spike in maternal deaths, unsafe deliveries, and untreated complications. In many contexts, community-based interventions or informal healthcare substitutes emerge to fill the vacuum, but these are frequently unregulated, inadequately resourced, and vulnerable to repression by state authorities.

Thus, the collapse of public health systems not only impairs healthcare access but also undermines legal obligations under international humanitarian and human rights law, particularly States' duties to respect, protect, and fulfil the right to health without discrimination, including in times of conflict and crisis.

6. Applicable International Legal and Normative Framework

a. CEDAW and Optional Protocol Jurisprudence

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 and often referred to as the international bill of rights for women, establishes a legally binding framework for state parties to eliminate discrimination against women in all spheres, including during armed conflict and in authoritarian contexts. CEDAW is unique among human rights treaties in that it explicitly addresses not only legal equality but also substantive equality, requiring states to take proactive measures to dismantle structural and indirect discrimination that impedes women’s access to rights, including healthcare.

Article 12 of CEDAW specifically obligates state parties to eliminate discrimination against women in the field of healthcare and to ensure access to appropriate services related to pregnancy, childbirth, and postnatal care. This provision has been interpreted by the Committee on the Elimination of Discrimination against Women to include access to sexual and reproductive health services as a core obligation. General

Recommendation No. 24 provides authoritative guidance that denial of access to reproductive healthcare constitutes a form of discrimination under the Convention.

The Optional Protocol to CEDAW, adopted in 1999, allows individuals and groups to submit complaints to the Committee when domestic remedies have been exhausted, thereby creating a mechanism for redress in cases where states have failed to fulfill their obligations. This has generated a growing body of jurisprudence on women's health rights in restrictive and conflict-affected environments.

One landmark case is Alyne da Silva Pimentel Teixeira v. Brazil, where the Committee found that Brazil violated Article 12 of CEDAW by failing to ensure appropriate maternal healthcare for a poor Afro-Brazilian woman, ultimately resulting in her death. The Committee emphasized that states must ensure not only formal access to services but also their effective availability and cultural appropriateness, particularly for marginalized women. While not arising directly in a conflict zone, this case established critical precedent for the application of CEDAW in conditions of systemic neglect and structural inequality, both of which are exacerbated in authoritarian and conflict contexts.

In the context of conflict, General Recommendation No. 30 expands on state obligations to uphold women's rights under CEDAW during armed conflict and occupation. It reaffirms that states are required to prevent violations by non-state actors, to regulate the conduct of armed groups under their control, and to ensure that military or security policies do not undermine women's access to essential services, including healthcare. It also recognizes extraterritorial obligations, affirming that state parties remain accountable for rights violations in territories under their effective control, including in occupied or blockaded regions where healthcare services are deliberately restricted.

For example, the Committee has raised concerns regarding barriers to reproductive health services in occupied Palestinian territories, including through the practice of movement restrictions and permit requirements imposed by Israeli authorities. These restrictions have resulted in delays and denials of emergency obstetric care, directly impacting maternal mortality and morbidity rates.

CEDAW's integration with other legal instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) reinforces the indivisibility of women's rights and strengthens the legal basis for state accountability in protecting health access during emergencies. Collectively, the Convention, the Optional Protocol, and the Committee's jurisprudence constitute a robust normative framework to assess and challenge violations of women's health rights in both conflict-affected and repressive governance settings.

b. IHL Provisions on Medical Access and Protection of Civilians

International Humanitarian Law (IHL) establishes binding obligations for all parties to an armed conflict to protect civilians and ensure their access to medical care without discrimination. The Geneva Conventions of 1949, particularly the First and Fourth Conventions, along with their Additional Protocols, form the cornerstone of these protections. Civilians, including women and girls, are granted special protection under these instruments both in international and non-international armed conflicts.

Article 3 common to the four Geneva Conventions requires humane treatment for all persons not taking active part in hostilities, and this includes access to medical services without adverse distinction. Additional Protocol I, Article 10, and Additional Protocol II, Article 7, affirm that the wounded and sick shall be respected and protected in all circumstances and shall receive medical care to the fullest extent practicable and with the least possible delay. These provisions explicitly prohibit attacks on medical units, personnel, transports, and facilities, and classify such acts as serious violations of international law. Attacks against hospitals, ambulances, and humanitarian health workers may constitute war crimes under the Rome Statute of the International Criminal Court.

In practice, these obligations are frequently undermined in modern conflicts, particularly those involving asymmetric warfare and siege tactics. In the Syrian conflict, for example, extensive documentation by the Commission of Inquiry and international NGOs has shown repeated aerial bombardments of hospitals in rebel-held areas, including the deliberate targeting of maternity clinics. These violations not only deny women access to reproductive and emergency care but also instill fear that deters civilians from seeking medical assistance. In Yemen, the blockade of ports and inspection delays have critically affected the import of medical supplies, including maternal health kits, further straining the health system and disproportionately affecting women and children.

The protection of medical access under IHL also extends to humanitarian corridors and evacuation routes. Parties to the conflict are required under Additional Protocol I, Article 70, to allow and facilitate rapid and unimpeded passage of humanitarian relief, including medical supplies. Arbitrary denial of such access, particularly when used as a method of warfare or collective punishment, constitutes a breach of IHL and may also trigger responsibility under International Human Rights Law if the state exercises effective control over the territory or population concerned.

States and non-state armed groups have a positive obligation not only to refrain from attacking medical services but also to actively facilitate humanitarian access. This includes issuing safe passage guarantees, removing administrative barriers to delivery, and ensuring that medical neutrality is respected. Failure to do so not only results in direct civilian harm but also undermines long-term post-conflict recovery, particularly for women whose access to sexual and reproductive health services is already compromised by structural inequalities.

International accountability mechanisms, including the International Criminal Court and the Independent International Fact-Finding Missions established by the Human Rights Council, have increasingly recognized patterns of systematic targeting of healthcare infrastructure as prosecutable offenses. These mechanisms, alongside the normative development of customary IHL, reinforce the inviolability of medical access even in high-intensity conflict zones.

c. UN Security Council Resolutions on Women, Peace, and Security

The Women, Peace, and Security (WPS) agenda, initiated through United Nations Security Council Resolution 1325 (2000), represents a legally and politically significant framework that compels Member States and UN bodies to integrate gender perspectives into peace and security processes. Resolution 1325 affirms that the disproportionate impact of conflict on women and girls, particularly through sexual and gender-based violence, must be addressed not only through protection mechanisms but also through their active participation in peacebuilding and post-conflict governance. The resolution recognizes women as agents of peace, not merely as victims, and calls for their full involvement in all stages of conflict resolution, peace negotiations, and humanitarian response.

Subsequent resolutions have expanded the normative and legal contours of the WPS framework. Resolution 2122 (2013) focuses on implementation gaps and mandates the inclusion of women's rights and gender equality considerations in all aspects of UN mission mandates. It strengthens accountability by emphasizing the need for Member States to report on progress, particularly in relation to access to reproductive health services and legal redress for victims of sexual violence in conflict zones. This is particularly relevant in contexts such as the Democratic Republic of the Congo, where systematic wartime sexual violence has been used as a strategy of war and women's access to healthcare and legal services remains severely restricted. Resolution 2122 reinforces the need to incorporate SRHR in humanitarian action as a core component of international response obligations.

Resolution 2467 (2019) builds on this by explicitly linking conflict-related sexual violence to structural gender inequality and underscores the importance of survivor-centered approaches. It calls for access to

comprehensive health services, including sexual and reproductive care, as part of reparative justice for victims. The resolution also stresses the critical need for the inclusion of civil society, particularly women-led organizations, in the design and implementation of protection and recovery mechanisms. An example of this operationalization can be seen in post-conflict Colombia, where peace agreements incorporated gender provisions after strong advocacy from women's organizations. Despite political resistance, these provisions have included commitments to sexual violence accountability and improved healthcare access in former conflict zones.

Together, these Security Council resolutions form a binding normative framework that obligates both conflict-affected states and the broader international community to integrate women's rights, including health rights, into all peace and security strategies. They affirm that violations such as denial of maternal health services, unsafe abortion due to lack of access, and targeted attacks on women healthcare workers in conflict settings are not isolated failures but breaches of international peace and security standards. As such, the WPS framework is directly applicable to the agenda of protecting women's rights and access to health services in conflict zones and authoritarian regimes and should serve as a foundational lens for committee deliberations.

7. Institutional and Operational Mechanisms for Protection

a. Mandates of UN Women, UNFPA, WHO, and OCHA (response and coordination under IASC)

The international response to the protection of women's rights and access to health services in conflict zones and authoritarian regimes is coordinated through a range of United Nations entities operating under the Inter-Agency Standing Committee (IASC) framework. The IASC is the primary mechanism for inter-agency coordination of humanitarian assistance, facilitating coherent, rights-based responses through sectoral clusters and cross-cutting mandates. Within this structure, UN Women, the United Nations Population Fund (UNFPA), the World Health Organization (WHO), and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) each hold distinct yet complementary mandates relevant to the protection of women's rights in crisis settings.

UN Women plays a normative and coordination role by promoting the integration of gender perspectives across humanitarian planning and policy development. It leads efforts to ensure the application of gender-sensitive frameworks such as the Gender Marker and supports gender advisors within Humanitarian Country Teams. UN Women also works to operationalize Security Council Resolution 1325 on Women, Peace and Security, particularly in integrating gender into early warning systems and post-conflict recovery planning. For example, in South Sudan, UN Women supported the deployment of women protection advisors who contributed to gender-based violence risk mitigation in coordination with peacekeeping forces and humanitarian agencies.

UNFPA serves as the lead agency for sexual and reproductive health (SRH) in humanitarian settings under the IASC Health Cluster and co-leads the Gender-Based Violence Area of Responsibility (GBV AoR) with UNICEF. UNFPA is responsible for the Minimum Initial Service Package (MISP) for reproductive health in emergencies, a standard that ensures the provision of life-saving services including maternal care, access to contraception, and clinical management of rape. In the Rohingya refugee response in Cox's Bazar, UNFPA established women-friendly spaces that provided confidential SRH services and psychosocial support to survivors of gender-based violence, demonstrating how coordinated humanitarian interventions can overcome access barriers in politically sensitive contexts.

WHO functions as the lead technical agency within the Health Cluster and coordinates the global health response to crises. It provides normative guidance, coordinates disease surveillance, and ensures that public health measures account for sex and gender dimensions. In conflict-affected areas such as Syria, WHO has

coordinated with local and international partners to deploy mobile clinics that ensure maternal health care reaches internally displaced women, even in besieged or opposition-held territories. WHO also tracks disruptions to essential health services and promotes the inclusion of SRHR indicators in health monitoring frameworks.

OCHA plays a critical role in coordinating overall humanitarian response through its management of Humanitarian Response Plans (HRPs) and coordination of the Central Emergency Response Fund (CERF). OCHA ensures that gender and protection principles are mainstreamed into humanitarian planning through the use of tools such as the Humanitarian Needs Overview and the Joint Intersectoral Analysis Framework. In contexts such as the Democratic Republic of the Congo, OCHA has worked with GBV sub-clusters to ensure coordinated protection strategies, especially for women and girls in areas of high insecurity.

Together, these institutions function within a broader system of accountability under the IASC, ensuring that gender equality and the right to health are upheld through multi-sectoral coordination, context-specific service delivery, and adherence to international humanitarian and human rights standards.

b. Access Constraints in Authoritarian Regimes (visa restrictions, retaliation against aid workers, data suppression)

Authoritarian regimes often impose severe limitations on humanitarian access, particularly when assistance or monitoring efforts relate to politically sensitive issues such as women's rights, sexual and reproductive health, or gender-based violence. These constraints may be administrative, legal, or informal, and are frequently used as tools of control to suppress external scrutiny, obstruct civil society operations, and limit the collection of evidence regarding human rights abuses.

One of the most common mechanisms of obstruction is the imposition of restrictive visa and registration regimes on international aid organizations and UN agencies. Governments may delay or deny visas for humanitarian workers, researchers, and medical professionals whose mandates include work on gender-based violence, maternal health, or reproductive rights. In countries such as Myanmar, the former military regime routinely delayed visa approvals for UNFPA and WHO staff, effectively stalling the deployment of mobile clinics and safe delivery kits to internally displaced women. Similar challenges have been observed in the Syrian Arab Republic, where humanitarian actors have been denied cross-line access to areas controlled by opposition groups, disproportionately affecting women’s access to maternal care and post-rape treatment.

Authoritarian governments may also engage in active retaliation against local humanitarian actors and healthcare providers perceived as cooperating with international organizations. This includes harassment, arrest, or deregistration of NGOs that provide reproductive health services or document sexual violence. In the Islamic Republic of Iran, civil society organizations involved in gender rights and women's health have faced routine surveillance, criminal prosecution, and public delegitimization. In some cases, such as in Nicaragua, the government has cancelled the legal status of women's rights organizations and health NGOs, thereby eliminating safe spaces for vulnerable women during crises.

Another core constraint involves suppression of medical and human rights data. Authoritarian regimes often restrict public access to data on maternal mortality, sexual violence, and access to contraception, especially during conflict or civil unrest. Data suppression serves to undermine both humanitarian response planning and international accountability efforts. During the conflict in Ethiopia’s Tigray region, access by UN agencies to data on gender-based violence and maternal health was heavily restricted, while medical supply chains were disrupted, further impeding accurate monitoring. In many such environments, reporting sexual violence or unsafe abortion becomes nearly impossible, not only due to legal risks for survivors but also because of state-imposed barriers to documentation.

These access constraints fundamentally impair the ability of the international community to meet its obligations under Security Council Resolution 1325 and related instruments. They also hinder the implementation of minimum initial service packages for reproductive health in emergencies, as outlined by the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises. Overcoming such constraints requires strategic engagement with regional institutions, use of remote programming models, and leveraging diplomatic channels to ensure that the principle of non-discrimination in access to health services is upheld even under authoritarian rule.

8. Accountability, Monitoring and Diplomatic Tools

a. Use of Commission of Inquiry (CoI), Special Procedures, and Treaty Body Reporting

Effective protection of women's rights and access to health services in conflict zones and authoritarian regimes requires robust international monitoring and accountability mechanisms. Among the key tools available to the United Nations system are Commissions of Inquiry (CoIs), Special Procedures of the Human Rights Council, and the treaty body reporting process under core human rights conventions. These mechanisms function both as investigative and normative instruments to document violations, trigger international responses, and compel states to fulfill their obligations under international law.

A Commission of Inquiry (CoI) is a fact-finding mission established by the Human Rights Council or other UN bodies with the mandate to investigate serious human rights violations, including those committed in armed conflict or under authoritarian rule. CoIs are typically granted a limited temporal mandate and focus on collecting evidence of violations of international human rights and humanitarian law. For example, the Independent International Commission of Inquiry on the Syrian Arab Republic, established in 2011, documented systematic gender-based violence including sexual violence in detention facilities and the targeting of female healthcare providers. Its findings have informed the work of the International, Impartial and Independent Mechanism (IIIM) and strengthened calls for international prosecutions. CoIs often make gender-sensitive recommendations, including the need for reparations, reform of discriminatory laws, and protection of access to healthcare in fragile governance settings.

Special Procedures refer to the system of independent experts, special rapporteurs, and working groups appointed by the Human Rights Council to monitor specific thematic issues or country situations. The Special Rapporteur on violence against women, its causes and consequences, has played a critical role in documenting abuses against women in conflict zones such as the Tigray region of Ethiopia and in authoritarian contexts like Iran, where state practices have involved arbitrary detention of female human rights defenders and restriction of access to reproductive health services. Special Procedures conduct country visits, issue communications to governments, and produce public reports that highlight structural violations and recommend urgent corrective actions. Their findings often serve as the basis for follow-up action by other UN bodies, donors, or international courts.

Treaty Body Reporting forms the backbone of the periodic review mechanism under the core international human rights instruments, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the International Covenant on Civil and Political Rights (ICCPR). States parties are obligated to submit regular reports detailing their implementation of treaty obligations. Treaty bodies, such as the CEDAW Committee, then issue Concluding Observations that assess compliance and recommend reforms. In recent reviews, for instance, the CEDAW Committee has expressed concern over the criminalization of abortion and denial of maternal health services in conflict-affected regions of Colombia and Myanmar, recommending legal reform and the expansion of access to health services for marginalized and displaced women. Treaty bodies also consider shadow reports submitted by civil society organizations, which are particularly important in authoritarian contexts where state narratives may obscure violations.

Collectively, these mechanisms contribute to building an evidence base, reinforcing state responsibility, and advancing diplomatic pressure through multilateral forums. While they lack direct enforcement authority, they are instrumental in generating political cost for non-compliance, informing the decisions of international donors, and laying the groundwork for accountability through regional or international tribunals. Their continued relevance depends on access, impartiality, and sustained engagement by states, international organizations, and women-led civil society actors.

b. Indicators-Based Monitoring under SDG 5 and 16 in Crisis Contexts

Monitoring the protection of women's rights and access to health services in conflict zones and authoritarian regimes requires a structured and data-driven approach. Within the framework of the 2030 Agenda for Sustainable Development, Sustainable Development Goals (SDGs) 5 and 16 offer critical benchmarks for assessing state performance and identifying protection gaps. SDG 5 focuses on achieving gender equality and empowering all women and girls, while SDG 16 addresses peace, justice, and strong institutions. When applied in conflict-affected or authoritarian contexts, indicators from these goals serve as both early-warning tools and accountability mechanisms.

Under SDG 5, relevant indicators include the proportion of women and girls aged 15 to 49 subjected to physical, sexual, or psychological violence, the proportion of women making their own informed decisions regarding sexual relations and reproductive health care, and the percentage of births attended by skilled health personnel. Monitoring these metrics in conflict zones such as Syria or South Sudan has revealed stark disparities, particularly in access to maternal healthcare and protection from gender-based violence. In Syria, for example, a UNFPA assessment found that over 70 percent of women lacked access to reproductive health services in active conflict areas, with reporting and verification hindered by insecurity and institutional collapse.

SDG 16 provides indicators to monitor the prevalence of violence, effectiveness of legal institutions, and access to justice. These are particularly useful in authoritarian regimes where judicial independence is compromised, and repression targets women human rights defenders, journalists, and healthcare providers. For instance, in Afghanistan following the Taliban's return to power, official data collection on gender-based violence ceased, legal redress mechanisms were dismantled, and civic spaces were suppressed, rendering conventional reporting structures non-functional. In such scenarios, shadow reporting and non-governmental observatories become essential to supplement gaps in state-led monitoring.

Operationalizing SDG indicators in crisis settings requires adaptation to local conditions and triangulation from multiple data sources including humanitarian assessments, health cluster data, mobile surveys, and civil society reporting. Organizations such as UN Women and the Global Observatory on Gender, Peace and Security have developed frameworks to align humanitarian response plans with SDG targets, thereby integrating real-time monitoring into relief efforts. These approaches enable both vertical accountability (to international bodies and donors) and horizontal accountability (to affected populations), reinforcing the international legal obligations of states even in periods of instability.

c. Leverage of Conditional Aid, Targeted Sanctions, and Multilateral Diplomacy

In conflict-affected and authoritarian settings, where domestic accountability is often weak or deliberately obstructed, the international community relies on a combination of financial leverage, diplomatic pressure, and collective action to promote compliance with human rights obligations, including those related to women's rights and access to health services. Conditional aid, targeted sanctions, and multilateral diplomacy form a triad of strategic tools that can compel behavioral change, deter further violations, and support protective mechanisms for women.

Conditional aid refers to the practice of linking the disbursement of development or humanitarian funding to a recipient state's adherence to specific human rights benchmarks. Donor states and international financial institutions increasingly use this tool to encourage policy reforms that enhance gender equality and healthcare access. For example, the European Union's Neighborhood Policy has included human rights conditionality in its financial support to states like Egypt and Tunisia, demanding improvements in gender legislation and the protection of civil society actors. Similarly, the United States has conditioned aspects of its security and economic assistance to countries such as South Sudan and the Democratic Republic of the Congo based on their cooperation with efforts to reduce sexual and gender-based violence in conflict.

Targeted sanctions, often referred to as "smart sanctions," involve the selective application of restrictive measures such as asset freezes, visa bans, or travel restrictions against individuals, entities, or government bodies implicated in serious human rights violations. Unlike broad-based sanctions, which can have harmful effects on the civilian population, targeted sanctions aim to hold perpetrators accountable while minimizing collateral damage. The United Nations Security Council, under its Women, Peace and Security agenda, has imposed sanctions on individuals in Mali and Libya for involvement in systematic sexual violence. The United States' Global Magnitsky Act and similar frameworks in Canada and the United Kingdom have also been used to sanction officials responsible for gender-based persecution in Myanmar and Iran, including those obstructing access to reproductive and emergency medical services for women.

Multilateral diplomacy involves coordinated action by international and regional organizations to apply normative and political pressure on states to fulfill their obligations under international law. It includes diplomatic démarches, joint communiqués, thematic dialogues, and the mobilization of intergovernmental forums such as the UN General Assembly, the Human Rights Council, and regional bodies like the African Union or Organization of American States. For example, the African Union's Maputo Protocol has served as a platform to demand state compliance with reproductive rights obligations. In Afghanistan, the collective diplomatic stance adopted by several UN Member States and agencies following the Taliban's restriction on women's access to health and education exemplifies the use of multilateral diplomacy to respond to authoritarian backsliding.

These tools are most effective when applied consistently, transparently, and in conjunction with robust monitoring mechanisms and independent verification. When employed with clear objectives and sustained engagement, conditional aid, targeted sanctions, and multilateral diplomacy can reinforce international norms, mitigate further harm, and amplify the voices of local women's rights defenders operating under threat.

9. Important Links

UNAUSA Rules of Procedure
drive.google.com/file/d/1Up_8hAqWkjBM1CDmfb5DgNj9908f0VJJ/view

UN Charter
https://treaties.un.org/doc/publication/ctc/uncharter.pdf

UN System Chart
https://www.un.org/en/pdfs/un_system_chart.pdf

Malcolm Shaw – International Law
https://drive.google.com/file/d/1Ap59YQ1dbtpCVoQtJGIswl-FkAWPz0Cu/view?usp=sharing

International Covenant on Economic, Social and Cultural Rights (ICESCR)
https://www.ohchr.org/sites/default/files/cescr.pdf

Convention on the Elimination of All Forms of Discrimination Against Women

https://www.ohchr.org/sites/default/files/cedaw.pdf

Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women
https://legal.un.org/avl/pdf/ha/opceafdw/opceafdw_e.pdf

UNSCR 1325
https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/WPS%20SRES1325%20.pdf

UNSCR 2122
https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_res_2122.pdf

UNSCR 2467
https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/s_res_2467.pdf

1st Geneva Convention
https://www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.30_GC-I-EN.pdf

2nd Geneva Convention
https://www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.31_GC-II-EN.pdf

3rd Geneva Convention
https://www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.32_GC-III-EN.pdf

4th Geneva Convention
https://www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.33_GC-IV-EN.pdf

Protocol additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III), 8 December 2005
https://ihl-databases.icrc.org/en/ihl-treaties/apiii-2005

Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I), 8 June 1977
https://ihl-databases.icrc.org/en/ihl-treaties/api-1977

Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), 8 June 1977
https://ihl-databases.icrc.org/en/ihl-treaties/apii-1977

Alyne da Silva Pimentel Teixeira v. Brazil
https://www.worldcourts.com/cedaw/eng/decisions/2011.07.25_da_Silva_Pimentel_v_Brazil.pdf

International Humanitarian Law
https://legal.un.org/avl/studymaterials/rcil-laac/2017/book1_2.pdf

International Human Rights Law
https://www.icrc.org/en/download/file/1402/ihl-and-ihrl.pdf

Women, Peace and Security (WPS) Framework
https://www.un.org/womenwatch/ianwge/taskforces/wps/Strategic_Framework_2011-2020.pdf