REPRODUCTIVE RIGHTS VIOLATIONS AS TORTURE AND CRUEL, INHUMAN, OR DEGRADING TREATMENT OR PUNISHMENT: A CRITICAL HUMAN RIGHTS ANALYSIS
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MISSION AND VISION

The Center’s Mission and Vision

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill.

Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality embodied in both the U.S. Constitution and the Universal Declaration of Human Rights. The Center works toward the time when that promise is enshrined in law in the United States and throughout the world. We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; and where every woman can exercise her choices without coercion or discrimination. More simply put, we envision a world where every woman participates with full dignity as an equal member of society.
TREATY-BASED ANTI-TORTURE AND CIDT PROVISIONS

Women and girls worldwide face a wide range of violations to their sexual and reproductive rights, such as lack of access to contraception and safe abortion, female genital mutilation (FGM), and sexual violence. Moreover, when accessing sexual and reproductive healthcare services women and girls encounter low-quality, often negligent and abusive care and treatment. These human rights violations often involve tremendous physical and psychological pain and arguably rise to the level of torture or CIDT, but historically they have not been recognized as such.

In recent years, the Center for Reproductive Rights (the Center) and other civil society organizations have extensively documented the ways in which abuses of women’s sexual and reproductive rights rise to the level of torture or CIDT and have advocated for recognition of the severity of these violations. The situation is continuing to change as international and regional human rights bodies and experts increasingly recognize that certain reproductive rights violations amount to torture or CIDT.

Establishing the most severe reproductive rights violations as a contravention of the right to be free from torture or CIDT can reinforce the urgency of addressing these issues and challenge impunity for such conduct. As the United Nations (UN) Committee against Torture (CAT Committee) has repeatedly stated, the right to be free from torture and CIDT carries with it non-derogable state obligations to prevent, punish, and redress violations of this right. By highlighting the links between the right to be free from torture and CIDT and other human rights, such as the right to the highest attainable standard of health, advocates can place greater pressure on states to take immediate and effective action to respect, protect, and fulfill women’s reproductive rights.

Recognizing these rights violations as forms of torture or CIDT reinforces states’ legal obligations to provide appropriate remedies and reparations. This analysis also challenges the traditional conception of reproductive rights as limited to the right to health; instead, it reveals the ways in which a broad range of human rights are implicated when reproductive rights are violated. Moreover, it provides advocates with greater leverage to demand government accountability and halt future violations.

This briefing paper analyzes torture and CIDT from a gender perspective in order to support recognition of certain reproductive rights violations as torture or CIDT. It also provides an overview of the evolving legal standards applicable to specific reproductive rights violations, including abuse in healthcare settings, coercive sterilization, denial of medical care (such as access to safe, legal abortion and post-abortion care), mistreatment and violence in detention and other custodial settings, and FGM. Case studies are included throughout the briefing paper to demonstrate the severity of harm caused by these reproductive rights violations, the complicity of the state in the violations, and the unjustified policy decisions that underlie them.

This briefing paper is a tool for advocates, lawyers, decision-makers, and other key stakeholders working on women’s human rights to assist them in framing reproductive rights violations as torture or CIDT. It aims to further the legal standards in this area and contribute to the recognition of certain reproductive rights violations as torture or CIDT by courts and human rights bodies at the national, regional, and international levels.

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TORTURE, CIDT, AND REPRODUCTIVE RIGHTS VIOLATIONS:
ANALYSIS FROM A GENDER PERSPECTIVE

The prohibition of torture and CIDT is one of the most firmly entrenched principles of international human rights law. Historically, torture and CIDT were understood to take place only in prisons and other traditional detention settings, during interrogations, and in conflict scenarios.

However, over time, human rights bodies and experts have increasingly recognized that persons may be at risk of torture or CIDT in other contexts or custodial settings, such as psychiatric institutions or orphanages. The CAT Committee, for example, has reaffirmed that states’ obligations to prevent, punish, and redress torture and ill-treatment apply not only to prisons but also to other “contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.”

Human rights bodies and experts have also begun to recognize that specific harms experienced by women and girls can constitute torture or CIDT and that these harms have particular consequences for their lives. The UN Special Rapporteur on Torture or Other Cruel, Inhuman or Degrading Treatment or Punishment (Special Rapporteur on Torture) has stated that the torture and CIDT framework should be applied “in a gender-inclusive manner with a view to strengthening the protection of women from torture.”

Fully integrating a gender perspective into the analysis of torture and CIDT is essential to ensure that states recognize and address violations of women’s human rights with the same urgency as other forms of torture and CIDT, and that states are held accountable for preventing, punishing, and redressing torture and CIDT as experienced by women. This is particularly important in the context of sexual and reproductive rights, since women are often vulnerable to torture and CIDT within healthcare, detention, and other custodial settings in part due to their sexuality, gender, and reproductive capacity. Without a gender framework, however, their claims may not be recognized as torture or CIDT.

The following section outlines state obligations to address torture and CIDT, the scope of state responsibility, and the key legal elements of torture and CIDT from a gender perspective. This section introduces a human rights analysis of torture and CIDT that encompasses the distinct harms and vulnerabilities that women face.
STATE OBLIGATIONS

Under international law, states have both negative obligations to refrain from committing acts of torture and CIDT and positive obligations to prevent, punish, and redress these violations. The UN Convention against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the International Covenant on Civil and Political Rights (ICCPR), and regional treaties require states to take effective legislative, administrative, judicial, and other measures to prevent, punish, and redress acts of torture and CIDT.1 Positive obligations, for example, include providing education and training for law enforcement personnel and others involved in detention or custodial settings to ensure that they exercise their power lawfully.2 The Protocol on the Rights of Women in Africa (Maputo Protocol) requires states to discourage customary, cultural, or religious practices inconsistent with the state's rights, duties, and obligations under the African Charter on Human and People’s Rights and to eradicate “elements in traditional and cultural beliefs, practices and stereotypes which legitimize and exacerbate the persistence and tolerance of violence against women.”3 When there are reasonable grounds to believe that torture or CIDT has been committed, states are generally required to conduct a prompt and impartial investigation, prosecute and take action against those who have committed torture or CIDT, and, in some cases, provide civil remedies to the survivors.4 (See text boxes on pages 6–7 for specific treaty provisions.)

The CAT Committee interprets state obligations to prevent torture as indivisible, interrelated, and interdependent with the obligation to prevent CIDT because “conditions that give rise to ill-treatment frequently facilitate torture….”5 It has also confirmed that states should continually “review and improve their national laws and performance under the Convention in accordance with the Committee’s Concluding Observations and views adopted on individual communications.”6 Thus, the content and scope of the CAT continues to evolve and expand to guarantee protection against torture and CIDT.

Ensuring special protection of minority and marginalized groups and individuals is a critical component of the obligation to prevent torture and CIDT. The CAT Committee and the Inter-American Court of Human Rights (Inter-American Court) have confirmed that states have a heightened obligation to protect vulnerable and marginalized individuals from torture, as individuals who face discrimination are generally more at risk of experiencing torture and CIDT. 7 Discrimination plays a prominent role in an analysis of reproductive rights violations as forms of torture or CIDT because sex and gender bias commonly underlie such violations.

SCOPE OF STATE RESPONSIBILITY

States generally bear responsibility for the acts and omissions of state agents as well as of private individuals and others acting in an official capacity, on behalf of the state, or in conjunction with the state.8 The CAT Committee has confirmed that “States parties are obligated to adopt effective measures to prevent public authorities and other persons acting in an official capacity from directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in acts of torture….”9 Human rights bodies also increasingly recognize that states are responsible for human rights violations committed by non-state actors when the state does not take all reasonable measures to prevent harm to individuals’ fundamental human rights and when it does not take effective action to punish and redress such harms.10 International human rights law has long recognized that states have a positive obligation to exercise due diligence in ensuring the enjoyment of human rights.11 This obligation extends not only to preventing human rights abuses by the state and its agents, but also to preventing abuses by non-state actors in the private sphere.12 The due diligence standard has emerged as a way to measure whether a state has fulfilled its obligations to prevent, punish, and redress torture and CIDT, including violations committed by non-state actors.

At the regional level, the Charter on the Rights of Children in Africa establishes that the prohibition of torture and CIDT applies to both state and non-state actors in the context of children’s rights.13 Additionally, Article 4 of the Maputo Protocol, which prohibits exploitation and CIDT, focuses on violence against women in both the private and public spheres, and thus by both state and non-state actors.

Dual Loyalty and Reproductive Rights

International standards on medical ethics generally mandate that healthcare providers “act in the patient’s best interests” and “owe his/her patients complete loyalty” putting the patient’s health above other considerations. At the same time, outside obligations to the government, employers, insurers, and other interested parties may compromise medical practitioners’ loyalty to their patients. These competing obligations or interests, often referred to as dual loyalties, are not uniformly problematic. However, when providers favor competing interests to the detriment of their patients’ health and well-being, patients’ human rights may be violated.

Although states bear the primary responsibility for guaranteeing human rights, healthcare professionals may become complicit in human rights violations by carrying out activities on behalf of the state that violate fundamental rights or by adhering to healthcare policies and programs that discriminate on the basis of sex or other prohibited grounds. For example, women’s reproductive rights are at stake when laws or policies restrict access to medically-necessary healthcare, such as safe abortion services, or condone coercive practices such as forced or coerced sterilization. Dual loyalty tensions play out, with attendant human rights consequences, when healthcare providers subordinate women’s fundamental rights to abide by these laws and policies. Restrictive abortion laws may criminalize abortion even when it is necessary to save a woman’s life or to preserve her physical or mental health, and provider compliance with these restrictive laws can jeopardize women’s fundamental rights to life, health, and freedom from torture or CIDT. Providers treating detained patients may be expected to ignore or accept the use of physical restraints on detainees during treatment, including during childbirth, despite the significant harms that shackling during labor may have for women’s physical and mental health.

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Professional ethical standards permit the subordination of loyalty to one's patient only to serve a higher social purpose. Discriminatory practices that violate human rights do not constitute a valid higher purpose and violate healthcare providers' ethical and human rights obligations. Healthcare practitioners should familiarize themselves with human rights standards and learn to identify situations of competing loyalties to ensure that patients' human rights and well-being are prioritized over these conflicting interests. Additionally, both the state and medical professional organizations have obligations to minimize harms arising out of dual loyalties. Professional organizations should establish clear standards that address problems of dual loyalty and human rights, ensure adequate training on and dissemination of these standards, and provide direct support for practitioners, particularly in high risk settings such as prisons. States should ensure that legislative and policy frameworks promote, rather than compromise, the realization of human rights in the healthcare setting.

3 Id. at 19.
4 Id. at 63.
5 Id. at 20.
6 Id.
7 Id. at 51-52.
8 Id. at 92-94.
9 Id. at 96-98.

Notably, the Inter-American Court addressed state responsibility for actions of private actors in the context of healthcare delivery in Ximenes Lopes v. Brazil. In that case, the Brazilian government was found responsible for violations of the rights to life and humane treatment of a mentally disabled youth in a private mental health facility affiliated with the Brazilian public health system. The Court noted that health is a public interest, the protection of which is a duty of the state. Thus, states “must prevent third parties from unduly interfering with the enjoyment of the rights to life and personal integrity, regardless of whether the entity providing such services is public or private in nature. This analysis would presumably apply to protection of the right to be free from torture, cruel, inhuman, and degrading treatment as well. To determine the scope of state responsibility, the UN Committee on the Elimination of Discrimination against Women (CEDAW Committee), the Inter-American Court, and the European Court of Human Rights (European Court) have applied the due diligence standard to states in the context of torture or CIDT. The Special Rapporteur on Torture has also confirmed that states have a duty to prevent acts of torture in the private sphere and called for a due diligence analysis when examining whether states have complied with their human rights obligations.

KEY ELEMENTS OF TORTURE AND CIDT IN THE CONTEXT OF REPRODUCTIVE RIGHTS VIOLATIONS

A gender analysis of torture and CIDT should build upon the definitions of these violations provided in the CAT and its authoritative interpretations. Article 1 of the CAT sets forth four essential elements of the definition of torture: 1) intentional infliction; 2) of severe pain and suffering (physical or mental); 3) for a specific purpose (i.e. to obtain information, intimidate, punish, or discriminate); and 4) with the involvement, instigation, consent, or acquiescence of a state official or person acting in an official capacity.

There is no international definition of CIDT. As a consequence, it is usually defined by its distinction from torture, as outlined in Article 1 of the CAT. International standards do, however, provide some guidance on the elements that comprise cruel, inhuman, and degrading treatment. Similar to torture, cruel and inhuman treatment, as defined in the CAT, requires evidence of severe pain or suffering. In order to constitute degrading treatment, however, it is sufficient to show that the act was aimed at humiliating the victim, regardless of whether severe pain was inflicted. While international legal standards do not provide a clear definition of what qualifies as “severe” pain or suffering, some insight has been shed at the regional level. Additionally, the CAT Committee has found that there is no need to prove an act was committed for an impermissible purpose in order to establish CIDT, and the Special Rapporteur on Torture has asserted that CIDT can be either intentional or negligent and with or without a specific purpose. Regional human rights treaties and jurisprudence have also established and developed the constitutive elements of torture and CIDT along similar lines as the CAT, with small variations.

There is a longstanding debate about whether torture and CIDT can and should be differentiated from each other or interpreted as a continuum of mistreatment. This is particularly relevant, for instance, in the context of healthcare settings where intent can be difficult to establish. In its General Comment No. 2, the CAT Committee confirmed that states’ obligations to prevent torture and CIDT or “ill-treatment” are “indivisible, interdependent and interrelated” and that the “definitional threshold between ill-treatment and torture is often unclear.” UN Treaty Monitoring Bodies, including the CAT Committee, often fail or decline to clearly delineate the legal standards they apply in distinguishing acts of torture from CIDT. By contrast, the European Court has confirmed that the drafters of the European Convention for the Protection of Human Rights and Fundamental Freedoms intended to make a clear distinction between torture and inhuman or degrading treatment, and the Court generally distinguishes between torture and CIDT based on the force of violence, severity of pain, and suffering inflicted. It is not the purpose of this briefing paper to provide a comprehensive analysis of the distinction between torture and CIDT. However, it is important to highlight the lack of a consistent approach across international and regional human rights mechanisms when making a gender analysis of torture and CIDT.
The section below analyzes the elements of torture and CIDT from a gender perspective and draws on the jurisprudence and emerging international standards in this area.

**Intent and Purpose**

The intent and purpose requirements for torture and CIDT are often closely linked. If a person acts with a particular purpose, he or she may also possess the requisite intent to engage in that action and to affect the results of that action. This is particularly the case with regard to women's reproductive rights, where violations are often based on gender discrimination and aimed at "correcting" behavior perceived as non-consonant with gender roles and stereotypes or at asserting or perpetuating male domination over women.47 For legal, political, and moral reasons on abortion and contraception have the discriminatory purpose and effect of denying women services that only they need42 and are based on the stereotypes that a woman's primary role is to bear children and that women lack the moral agency to make decisions about their sexuality and reproduction.43 Moreover, legislators who pass such laws knowing that they are likely to have a detrimental effect on the health of women and girls arguably act with the intent to inflict harm for a discriminatory purpose.44 Similarly, healthcare workers who inflict physical and mental pain and suffering on women in the provision of post-abortion care may also act with discriminatory intent and purpose due to their bias against women who choose to have an abortion.

Some experts have asserted that one does not have to establish intent to prove torture when the purpose of the conduct is clear.45 The Special Rapporteur on Torture has confirmed that the “purpose element is always fulfilled, if the acts can be shown to be gender-specific” since such violence is inherently discriminatory and “discrimination is one of the elements mentioned in the CAT definition.”46 Furthermore, the Special Rapporteur has stated that, once the specific purpose of the act has been established, the act’s intent can be implied.47

**Severity of Harm**

No clear analytical criteria have been established within the international system to gauge the level of severity that constitutes torture or cruel and inhuman treatment. However, it is clear that international and regional human rights bodies measure the “intensity” of alleged conduct based on both objective factors (duration of the conduct, physical and mental effects of the conduct, and manner and execution of the conduct) and subjective factors (including sex/gender, age, and the victim’s state of health).48 The Inter-American Commission and Court have applied a heightened standard of scrutiny to measure the intensity of suffering for youth and people with mental disabilities.49

Subjective factors play an important role in determining the severity of harm, and human rights bodies have established sex and gender as key factors for assessing the level of pain and suffering experienced. Recently, human rights bodies have begun to recognize that women experience pain and suffering in a particular way due to their sex and gender and that the consequences of such harm might also be different for these same reasons.

In the case of Miguel Castro-Castro Prison v. Peru, for example, the Inter-American Court handed down one of the first decisions using a gendered analysis of CIDT. The case involved women, some of whom were pregnant, who were detained in a maximum security prison where they were humiliated, stripped, held in solitary confinement, denied medical care, prevented from communicating with their families and attorneys, and subjected to intense physical and psychological abuse.49 The Court found that the forced nudity was particularly grave for the women who were subjected to it48 and that it caused them “serious psychological and moral suffering, which is added to the physical suffering they were already undergoing due to their injuries.”50 The Court asserted that these attacks constituted sexual violence and a violation of the right to humane treatment under the American Convention on Human Rights (Article 5).51 Furthermore, the Court established that the state violated the right to a fair trial and judicial protection, as required under the Inter-American Convention to Prevent and Punish Torture (Articles 1, 6, and 8)52 and failed to engage in due diligence to prevent, investigate, and impose penalties for violence against women, as required under the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Article 7(b)).53

**State Control, Custody, or Consent**

Under international human rights law, states have the obligation to prevent, punish, and redress torture and CIDT committed by state agents and others acting in an official capacity.54 Furthermore, states also bear responsibility for acts of torture or ill-treatment committed by non-state or private actors when state authorities or others acting in an official capacity know or have reasonable grounds to believe that these acts are taking place and do not exercise due diligence to “prevent, investigate, prosecute and punish” these acts.55 The Special Rapporteur on Torture has affirmed that the definition of torture under the CAT “clearly extends State obligations into the private sphere and should be interpreted to include State failure to protect persons within its jurisdiction from torture and ill-treatment committed by private individuals.”56 The UN Human Rights Committee (HRC) has also affirmed that torture and CIDT prohibitions “clearly [protect] not only persons arrested or imprisoned, but also ... patients in educational and medical institutions.”57 The CAT Committee, through the adoption of the Optional Protocol to the CAT, has also broadened the concept of “deprivation of liberty” by creating a subcommittee to inspect locations that involve “any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.”58 An example of this in the context of reproductive rights would be a hospital where women are detained for inability to pay their medical bills.59

Moreover, Treaty Monitoring Bodies including the HRC and the CAT Committee have emphasized that state obligations to address torture and CIDT extend to contexts of custody and control such as schools, other institutions that provide care to children, and healthcare settings.60 States are also obligated to address torture and ill-treatment in “other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.”61 Thus, the
protection extends to both public and private educational settings, for example, where girls are subjected to sexual violence at the hands of teachers and administrators who exercise control and authority over them.64

The CAT Committee has also confirmed that women are vulnerable to torture or ill-treatment in the context of “deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence by private actors in communities and homes”65 and that they may be subject to violations of the CAT on the basis of their “actual or perceived non-conformity with socially determined gender roles.”66

A clear example of this is the ill-treatment of women who seek post-abortion care, which is often a form of punishment for noncompliance with their traditional role as child-bearers.67

The Special Rapporteur on Torture has incorporated the concept of powerlessness into his analysis of what constitutes torture and CIDT, explaining that “the overriding factor at the core of the prohibition of CIDT is the concept of powerlessness of the victim.”68 A “situation of powerlessness arises when one person exercises total power over another, classically in detention situations, where the detainee cannot escape or defend him/herself.”69 If the coercion in those circumstances “results in severe pain or suffering inflicted to achieve a certain purpose,” it must be considered torture or CIDT, according to the Special Rapporteur.70 The Special Rapporteur has applied the powerlessness concept to gender-specific harms such as FGM, which usually takes place before a girl’s tenth birthday when she is still under “complete control of parents and communities and [does] not have the possibility of resisting.”71

The Inter-American Court’s decision in Miguel Castro-Castro Prison v. Peru, discussed above, pointed out the relevance of the context in which the acts of ill-treatment were carried out for determining the state’s responsibility, since “the women who suffered them were subject to the complete control and power of State agents, absolutely defenseless, and they had been injured precisely by State police officers.”72

The powerlessness analysis is particularly important for women’s human rights, including reproductive rights, as it broadens the analysis of torture and CIDT to situations where women are under the control of other parties against their will. Notably, the Special Rapporteur on Torture’s proposed consideration of powerlessness aligns with the approach currently taken by human rights bodies in the European and Inter-American systems, which gauge the severity of alleged conduct in part by considering the specific status of the victim, “such as sex, age and physical and mental health, in some cases also religion, which might render a specific person powerless in a given context.”73

“Reproductive rights violations carried out in detention and other settings may amount to torture or CIDT in certain circumstances.”
Both the European Court and the Inter-American Court have stated that “the definition of torture is subject to ongoing reassessment in light of present-day conditions and the changing values of democratic societies.”

Although certain reproductive rights violations have not been widely analyzed as forms of torture or CIDT, international and regional human rights bodies and experts increasingly recognize the severity of physical and mental harm caused by these violations and in some circumstances have deemed such violations a direct contravention of the right to be free from CIDT. These bodies have recognized that abuses in healthcare settings, denial of medical care, mistreatment and violence in detention and custodial settings, and FGM may rise to the level of torture or CIDT. The section below provides an analysis of these rights violations as forms of torture or CIDT.

VIOLATIONS IN HEALTHCARE SETTINGS

Women seeking medical care may experience abuse and mistreatment at the hands of healthcare personnel, who hold clear positions of authority and often exercise significant control over women in these contexts. In certain situations, women may find themselves dependent on healthcare providers who deliberately limit their ability to make autonomous decisions about their treatment and care. Healthcare providers are generally in a position of authority over patients, thus women may find themselves in a state of powerlessness that makes them vulnerable to abuse. These abuses are often exacerbated when the health services they seek, such as abortion, are highly stigmatized.

Abuse of Women in Healthcare Settings

Abuse and mistreatment of women in healthcare settings is not uncommon. Women seeking care face abuses that include detention in appalling conditions if they are unable to pay hospital fees and physical and verbal abuse.

In 2007, the Center and FIDA–Kenya published Failure to Deliver: Violations of Women’s Human Rights in Kenyan Health Facilities, which documented widespread and systemic problems with the provision of reproductive healthcare services in Kenya. The report found that women in Kenya suffer multiple rights violations, including physical and verbal abuse when seeking maternity services, detention with their babies in healthcare facilities due to unpaid medical bills, and staff and equipment shortages that impair the ability of healthcare personnel to provide quality care. The report demonstrated that verbal and physical abuse in healthcare facilities—especially before, during, and after childbirth—inflicts upon women’s physical and psychological integrity, arguably violating the right to be free from CIDT. Additionally, the report established that extended delays before receiving medical attention during labor or while waiting for stitches after delivery—as well as being stitched without anesthesia—cause women physical and emotional suffering.

The report also found that the practice of detaining women in medical facilities—often in inhumane conditions—because they cannot pay their medical bills could also amount to a violation of the right to be free from torture and CIDT.

The case of M.M. v. Peru exemplifies the problem of torture and CIDT within a healthcare setting. The case involved a 19-year-old Peruvian woman who was drugged and then raped by a healthcare provider in a public hospital when she came in for medical services. After filing a criminal report immediately thereafter, M.M. was subjected to further mistreatment and discrimination by the criminal justice system. The doctor was acquitted despite evidence indicating his guilt. The Center, the Latin American and Caribbean Committee for the Defense of Women’s Rights, and the Center for Justice and International Law filed a petition with the Inter-American Commission on behalf of M.M., alleging violations of her rights to physical and psychological integrity, liberty, and dignity, among others.

The CAT Committee recently expressed concern about rights violations in healthcare facilities in its concluding observations to the Austrian government. In particular, the Committee noted “reports of alleged lack of privacy and humiliating circumstances amounting to degrading treatment during medical examinations” at a community health center “where registered sex workers are required to undergo weekly medical checkups, including gynaecological exams, and to take regular blood tests for sexually transmitted diseases.”

The Committee called upon the government to ensure that “medical examinations are carried out in an environment where privacy is safeguarded and in taking the greatest care to preserve the dignity of women being examined.”

Coercive Sterilization

Coercive sterilization is a grave human rights violation that is frequently targeted at women from marginalized segments of society. For example, the Center and its partner Vivo Positivo recently sought redress from the Inter-American Commission on behalf of a rural Chilean woman who was sterilized without her consent after giving birth because of her HIV-positive status (see F.S. v. Chile, text box). Similarly, in its report Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia, the Center and its partners documented widespread coercive sterilization of Roma women in Slovakia’s government-run health facilities and also found that these women often received misinformation on reproductive health matters, were discriminated against in their access to healthcare goods and services, were physically and verbally abused by medical providers, and were denied access to their medical records. In these cases, healthcare personnel often perform coercive sterilization based on the discriminatory belief that women living with HIV or who are Roma should not have children and with the improper purpose of preventing them from conceiving. Furthermore, coercive sterilization usually occurs while a woman is giving birth or soon after, when she is in a position of powerlessness at the hands of healthcare providers who do not obtain her full and informed consent to sterilization.
F.S., a young rural Chilean woman, was sterilized without her informed consent after giving birth because of her HIV-positive status. F.S. was screened for HIV as part of routine prenatal tests but she did not receive any counseling on the subject beforehand. She was surprised and dismayed when the results came back positive, but was relieved to learn that she could still have a healthy child and sought the necessary treatment to minimize the risk of transmission. F.S. reported to the hospital for her scheduled cesarean section, but went into labor the night before and had to undergo an emergency cesarean section. During labor, she was mistreated by nurses and hospital staff who made it clear that they did not want to provide care to her because of her HIV status. Without speaking to F.S. about sterilization or family planning methods, the surgical team administered anesthesia, and F.S. slept while they operated on her. The next morning, F.S. was shocked to learn that she had been sterilized during the operation. She and her husband had always dreamed of having a big family. As the news of her sterilization began to sink in and she shared the disturbing information with her husband, F.S. became severely depressed.

The Center and Vivo Positivo, a Chilean non-governmental organization working on the rights of HIV-positive persons, recently submitted a case to the Inter-American Commission on Human Rights on behalf of F.S. alleging violation of her rights to physical and mental integrity; humane treatment; freedom from gender-based violence; personal liberty and security; privacy; family life; and equality and non-discrimination, among others.

Experts recognize that the permanent deprivation of one’s reproductive capacity without informed consent generally results in psychological trauma, including depression and grief.90 The HRC has stated that coercive sterilization violates the right to be free from torture and CIDT, as provided under the ICCPR.85 Similarly, the CEDAW Committee has stated that “States parties should not permit forms of coercion, such as non-consensual sterilization, that violate women’s rights to informed consent and dignity,” affirming that coercive sterilization infringes on the rights to human dignity and physical and mental integrity.85 Moreover, human rights bodies and experts have repeatedly emphasized the need to obtain informed consent for sterilization procedures.92 Notably, the Special Rapporteur on Violence against Women has asserted that “forced sterilization is a method of medical control of a woman’s fertility without the consent of a woman. Essentially involving the battery of a woman—violating her physical integrity and security—forced sterilization constitutes violence against women.”96

In recent years, the CAT Committee has explicitly addressed contraceptive sterilization in its concluding observations. For example, the Committee expressed concern to the governments of the Czech Republic and Slovakia regarding “irresistable sterilizations of Roma women”91 and called upon the states to investigate these claims.91 The Committee called upon the Slovak government to “prosecute and punish the perpetrators and provide the victims with fair and adequate compensation.”94 The Committee also called on the state to effectively enforce the country’s healthcare legislation by “issuing guidelines and conducting training of public officials, including on the criminal liability of medical personnel conducting sterilizations without free, full and informed consent, and on how to obtain such consent from women undergoing sterilization.”96 The Committee also issued concluding observations to Peru that expressed concern about the practice of coercive sterilization as well as the fact that “the State party has failed to take steps to prevent acts that put women’s physical and mental health at grave risk and that constitute cruel and inhuman treatment.”97

Finally, the Special Rapporteur on Torture has emphasized that forced abortions and sterilization of women with disabilities may constitute torture or CIDT when they are conducted with the legal consent of the person’s guardian but against the disabled woman’s will.98 The Special Rapporteur has also asserted that “forced abortions or sterilizations carried out by State officials in accordance with coercive family planning laws or policies may amount to torture.”99

DENIAL OF MEDICAL CARE

Women and girls seeking reproductive healthcare services may experience denial of care due to discrimination, stigma, and negative gender stereotypes. In many instances, for example, abortion and post-abortion medical care are necessary to safeguard women’s and girls’ lives and health. But all too often, women and girls are denied access to these medical services due to restrictive laws and policies or healthcare personnel’s decision not to provide legal services because of their own objections or discriminatory attitudes toward the woman seeking services. Furthermore, women may be denied medical care solely on the basis of their social status—such as being from a minority ethnic community or being HIV-positive. Human rights bodies have recognized that, in some circumstances, these denials of service may violate the right to be free from torture or CIDT.

Access to Abortion

International and regional human rights bodies have increasingly recognized that restrictive abortion laws violate women’s human rights.90 Moreover, they have affirmed that in cases where abortion is legal, it needs to be accessible.92 However, women are often denied access to abortion arguable with the discriminatory and improper purpose of discouraging them from terminating a pregnancy. This denial can cause tremendous pain and suffering and have long lasting consequences for women’s health and lives.

In the case of S. and T. v. Poland, the denial of legal abortion services led to the foreseeable pain and suffering of an adolescent girl, which arguably constitutes inhuman treatment.103 T., a 14-year-old Polish girl, wanted to terminate a pregnancy resulting from a rape. T.’s mother supported her daughter’s decision. They obtained a certificate from the prosecutor’s office indicating that she had been raped and went to the public hospital to receive a referral for a lawful abortion. After T. was admitted to a hospital, she was temporarily taken from her mother’s custody in an attempt by healthcare personnel to convince T. not to terminate her pregnancy. Healthcare personnel also leaked T.’s personal information to anti-choice advocates who subsequently harassed T. for weeks.
Denial of Abortion Services: K.L. v. Peru

In the landmark decision of K.L. v. Peru, the HRC deemed the denial of a therapeutic abortion that put the petitioner’s (K.L.) physical and mental health at risk a violation of her fundamental right to be free from CIDT, as recognized under Article 7 of the ICCPR. The K.L. case involved a 17-year-old girl who was pregnant with an anencephalic fetus, which posed risks to her life and mental health if the pregnancy continued. In cases of anencephaly, either the fetus does not survive to term or the baby dies shortly after being born. Although doctors diagnosed K.L.’s pregnancy as posing risks to her life and health and recommended its termination, state hospital authorities ultimately denied K.L.’s request for an abortion, claiming it fell outside the health and life exceptions to Peru’s abortion ban. K.L. was forced to continue her pregnancy to term and gave birth to an anencephalic girl, whom she was coerced to breastfeed during the four days the baby survived. K.L. was subsequently diagnosed with severe depression requiring psychiatric treatment.

In 2005, the HRC found the Peruvian government in breach of its ICCPR obligations for denying access to a therapeutic abortion permitted by its own domestic law. The HRC reasoned that K.L.’s depression and emotional distress were foreseeable and the state’s omission in “not enabling [her] to benefit from a therapeutic abortion was ... the cause of the suffering she experienced.”

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Post-Abortion Care

Human rights violations in the context of post-abortion care are often directly related to the legal status of abortion in a country and the stigma surrounding the procedure. For example, the Center’s fact-finding report in Harm’s Way: The Impact of Kenya’s Restrictive Abortion Law documents how women in Kenya seeking abortion and post-abortion care often are subjected to verbal and physical abuse, delays or denials of treatment or pain medication, unreasonable user fees, and threats of being reported to law enforcement for violation of criminal abortion laws. These acts are arguably carried out for the improper purpose of discouraging women from seeking healthcare and as a punishment for not fulfilling their traditional role as child-bearers. At the time the report was written, Kenya had one of the most restrictive abortion laws in the world, criminalizing abortion except to save the life of the pregnant woman. The report found that women and girls with unwanted and unplanned pregnancies often resort to unsafe, clandestine abortions, which can lead to devastating health complications and even death. Women seeking post-abortion care often have to pay bribes to healthcare providers to obtain services, and they may find themselves detained in healthcare facilities if they are unable to pay their bills after receiving care. Medical centers in Kenya also lack trained personnel and equipment to perform post-abortion care, and the stigma surrounding this essential medical service, which is always legal, exposes women to verbal abuse and the withholding of available pain management by healthcare providers.

The Center also documented the devastating effects of criminal abortion bans and their impact on the delivery of post-abortion care in its recent report Forsaken Lives: The Harmful Impact of the Philippine Criminal Abortion Ban. The report confirmed that Filipino women die or suffer grave complications from unsafe abortion procedures and are denied life-saving post-abortion care due to the Philippines’ archaic abortion law and the stigma surrounding the procedure. The report also revealed that the criminal prohibition of abortion has heavily stigmatized the delivery and receipt of abortion-related services, resulting in humiliating treatment, substandard care, and discrimination in the delivery of post-abortion care, even though such care is legal in the Philippines. For example, women seeking post-abortion care suffer verbal abuse, threats of criminal sanctions, neglect, and violations of patient confidentiality, and at times have been coerced to confess that they underwent an illegal abortion. The women experienced these violations when they were seeking services in medical facilities and were in a vulnerable position.
UN human rights bodies have addressed access to and abuses around post-abortion care in their concluding observations to states. The CAT Committee has called upon the Chilean government to “eliminate the practice of extracting confessions for prosecution purposes from women seeking emergency medical care as a result of illegal abortion; investigate and review convictions where statements obtained by coercion in such cases have been admitted into evidence, and take remedial measures including nullifying convictions which are not in conformity with the Convention.”110 The Committee further called upon the government to “guarantee immediate and unconditional treatment of persons seeking emergency medical care,” in line with World Health Organization guidelines.111 The Committee issued the same recommendation to the Nicaraguan government in response to its absolute ban on abortion.112

The denial of care or the provision of inferior care can clearly cause severe physical and mental pain and suffering. The Special Rapporteur on Torture has made an explicit link between the denial of pain relief and the prohibition of torture and CIDT, and has affirmed that such a denial constitutes CIDT if it causes severe pain and suffering.113 The Special Rapporteur has further affirmed that states’ failure to take reasonable measures to ensure accessibility of pain treatment calls into question their compliance with their positive obligations to protect their citizens from inhuman and degrading treatment.114

**Denial of Care Based on Health Status**

Ill-treatment of women in healthcare settings is often exacerbated by discrimination based on grounds such as health status. One example is the case of Gita Bai, a 30-year-old low-income Indian woman who was abused and experienced denial of care for being HIV positive.115 On March 31, 2007, Bai went to a local hospital in Madhya Pradesh for treatment for her fifth pregnancy. After a preliminary examination, she was taken to the ward for admission. However, once the medical staff realized she was HIV positive they discharged her without providing medical treatment. A few days later, when Bai returned to the hospital with labor pains, doctors forcibly prevented her from re-entering the premises because of her HIV-positive status. Bai was forced to deliver her child on the street outside the hospital and died a few days later from delivery complications that could have been prevented with quality maternal healthcare. The hospital did not perform a post mortem and attempted to dispose of her body quickly. The police refused to register a formal complaint against the hospital for Bai’s death.116

**MISTREATMENT OF WOMEN IN DETENTION AND OTHER CUSTODIAL SETTINGS**

Reproductive rights violations carried out in detention and other custodial settings may amount to torture or CIDT in certain circumstances. As discussed above, any facility where an individual’s movements or ability to make autonomous decisions are restricted, either because of the presence of state authority or the impression of such authority, may qualify as a place of detention under international legal standards. This section outlines some of the reproductive rights violations women experience in traditional detention settings as well as other custodial settings, such as schools, that may rise to the level of torture or CIDT.

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**Maternal Death from Denial of Life-Saving Medical Care: Z. v. Poland**

Z.’s daughter, a Polish woman in her twenties, was repeatedly denied diagnostic care and necessary treatment for her ulcerative colitis (UC) while she was pregnant. UC is a disease that causes inflammation and sores in the rectum and colon; it is not a disease caused by pregnancy. In May 2004, Z.’s daughter was informally she was four to five weeks pregnant. It was a wanted pregnancy, and Z.’s daughter was engaged to be married in July 2004. Around the time Z.’s daughter became pregnant, she also began experiencing symptoms of UC such as nausea, abdominal pains, vomiting, and diarrhea with blood. While she was initially told that the symptoms were pregnancy-related, they rapidly worsened, requiring multiple hospitalizations. During these hospital stays, she received minimal treatment and her doctors failed to carry out further diagnostic tests to decide on the proper course of treatment. Instead, she was transferred from hospital to hospital and sent home again in early July. No steps were taken to control her disease.

The daughter’s condition deteriorated over the next few months, and she developed abscesses that required surgical removal. Time and again, however, more extensive testing and aggressive treatment to control her disease were denied. One doctor told Z. that her daughter was “too interested in her own ass instead of being interested in something else,” the “something else” being her pregnancy. Although abortion was not at issue, other doctors told Z.’s daughter they could not treat her because their “conscience did not allow” them to do so. Contrary to medical consensus, they were concerned that providing the necessary treatment could lead to termination of her pregnancy.

None of the daughter’s doctors registered their conscientious objection or referred her to a doctor who would give her the necessary life-saving treatment. In early September 2004, Z.’s daughter was hospitalized with blood poisoning and symptoms of organ dysfunction. Doctors also diagnosed her fetus as dead. Although many surgeries to remove pus and ulcers, the sepsis became more severe and her kidneys failed. After months of extreme pain and humiliation at the hands of her doctors, Z.’s daughter died on September 29, 2004, of a condition that could have been controlled with proper and timely treatment. In 2008, the Center and the Reproductive Rights Legal Network of the Polish Federation for Women and Family Planning submitted a petition to the European Court asserting that medical care that disregards a pregnant woman’s health in favor of that of her fetus violates the woman’s rights to life, freedom from torture or cruel, inhuman, and degrading treatment, respect for private life, and non-discrimination.
Shackled During and After Delivery: The Shawanna Nelson Case

Shawanna Nelson was six months pregnant with her second child when she was incarcerated for a nonviolent offense by the Arkansas Department of Corrections in 2003.

Nelson’s legs were shackled to the sides of a hospital bed for hours while she was in labor. She was unable to move her body to relieve pain due to the physical restraints. Nelson was briefly unshackled during childbirth, but was immediately re-shackled after delivering her son. She subsequently soiled her sheets with human waste, but was unable to abate the humiliating and unsterile condition due to her inability to move. Advocates filed a suit against the state of Arkansas for violating Nelson’s constitutional Eighth Amendment right against cruel and unusual punishment, arguing that Nelson’s shackling caused her both physical pain and emotional trauma and jeopardized the safety of the child she was about to deliver. On October 2, 2009, the Eighth Circuit Appellate Court ruled that constitutional protections against shackling of pregnant women during childbirth are clearly established by the U.S. Constitution and the law of Arkansas.115 The Court similarly issued concluding observations to the United States recommending that the government prohibit shackling of pregnant women during childbirth in order to be in compliance with its obligations under the ICCPR.116

The Special Rapporteur on Torture has stated that pregnant women “should not be deprived of their liberty unless there are absolutely compelling reasons to do so and their particular vulnerability should be borne in mind” and that “measures of physical restraint should be avoided during delivery.”118 The Special Rapporteur on Violence against Women also concluded that the use of restraints during transport to the hospital and during and after delivery violates international standards and “may be said to constitute cruel and unusual practices.”119

Sexual Abuse in Detention Settings

Women in detention facilities and other custodial settings face a heightened risk of sexual violence from other detained individuals and authorities. In these contexts, rape of detained women has been increasingly recognized as a form of torture. For example, the European Court in Aydin v. Turkey deemed the rape of a detainee an “especially grave and abhorrent form of ill-treatment given the ease with which the offender can exploit the vulnerability and weakened resistance of his victim and find that the act constituted torture.”114 The Court further observed that rape “leaves deep psychological scars on the victim which do not respond to the passage of time as quickly as other forms of physical and mental violence.”113

Sexual Violence in Schools

Similar to criminal detention centers and medical settings, students within the custodial care of schools and school personnel are often vulnerable to abuse and sexual violence. The CEDAW Committee has defined sexual violence as a form of discrimination against women122 and has frequently expressed concern about state failure to address sexual harassment against women,123 including in school settings.124 The UN Committee on the Rights of the Child has also confirmed that states are obligated to protect children from all forms of violence and abuse, including in schools.125

An extreme example of sexual violence in an educational setting is the case of Paola Guzmán v. Ecuador126 Paola was sexually harassed and abused by her school’s vice principal for two years and became pregnant by him at age 16. The vice principal enlisted a school doctor to terminate the pregnancy, but the doctor made this conditional on Paola having sex with him. In December 2002, Paola committed suicide by ingesting diablillos (commercially available pill-sized explosives, commonly used for suicide) containing white phosphorous. Paola’s parents initiated criminal, administrative, and civil proceedings; however, these proceedings have been plagued by mistakes, irregularities, and systematic ineffectiveness. Moreover, Ecuador’s Ministry of Education has failed to take effective steps to address these types of violations. The Center and the Ecuadorian non-governmental organization Centro Ecuatoriano para la Promoción y Acción de la Mujer (CEPAM–Guayaquil) filed a petition before the Inter-American Commission in 2006, alleging that the Ecuadorian government deprived Paola of her rights to life, personal integrity, personal security, humane treatment, freedom from violence, non-discrimination, judicial guarantees, and judicial protection, and to the measures of protection required by her condition as a minor under regional and international instruments.127 While the Inter-American Commission declared the case admissible in February 2009 and the parties have explored the possibility of a friendly settlement, the Ecuadorian government has yet to provide Paola’s parents any redress for the loss of their daughter.128

Shackling of Pregnant Detainees

UN human rights bodies and experts are paying increasing attention to the practice of shackling incarcerated pregnant women and have found that it may amount to torture or CIDT. In the United States, pregnant women detained in prisons, jails, and immigration detention centers are routinely restrained by their ankles and/or wrists when they are transported for medical care. They often remain shackled during labor, delivery, and the post-delivery recovery period for hours or even days, despite the presence of armed guards. The CAT Committee expressed concern in its concluding observations to the United States regarding the treatment of detained women in prisons and jails, including the practice of gender-based humiliation and incidents of shackling of women detainees during childbirth.115 The Committee recommended that the United States “adopt all appropriate measures to ensure that women in detention are treated in conformity with international standards.”116 The HRC similarly issued concluding observations to the United States recommending that the government prohibit shackling of detained women during childbirth in order to be in compliance with its obligations under the ICCPR.117

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2 Id. at 17-18.
FEMALE GENITAL MUTILATION

FGM has extreme physical and psychological consequences for women and girls,\(^1\) with the pain and trauma inflicted by it often continuing beyond the actual procedure.\(^2\) The HRC has deemed FGM a violation of the right to be free from torture and CIDT under the ICCPR.\(^3\) As noted in the case study M.N.N. v. Attorney General of Kenya, FGM is traumatizing both at the moment it occurs and from that point forward. FGM has thus been found to amount to “continuing and permanent persecution” in the refugee context.\(^4\)

The CAT Committee has generally addressed FGM within its interpretations of Article 16 of the CAT, which calls for the prevention of CIDT.\(^5\) In one instance, the Committee explicitly referenced FGM as a traditional practice that “violat[es] the physical integrity and human dignity of women and girls” and constitutes CIDT.\(^6\) The Committee has commended states for passing legislation banning FGM,\(^7\) expressed concern regarding the lack of such legislation,\(^8\) and recommended the passage of such legislation.\(^9\) The Committee has also recommended the implementation of nationwide education and awareness campaigns\(^10\) and investigation,\(^11\) prosecution,\(^12\) and punishment of perpetrators of FGM\(^13\) as means to eradicate the practice.

Along similar lines, the Special Rapporteur on Torture has stated that any act of FGM may amount to torture, regardless of whether it is legal, and that “medicalization” of FGM and its provision within public or private clinics does not make the practice acceptable.\(^14\) On the contrary, failure to prosecute physicians carrying out the procedure amounts to de facto consent to the practice by the state, rendering the state accountable.\(^15\)

M.N.N. is a Kenyan woman who suffered FGM in a hospital after giving birth. On June 8, 2005, M.N.N. went to a mission hospital on the outskirts of Nairobi to deliver her second child. During M.N.N.’s initial exam, the healthcare provider physically and verbally mistreated her and touched her genitals in an unnecessary and inappropriate manner. M.N.N. felt humiliated and feared for her own well-being and that of her child; however, she was unable to protect herself because she was in labor. After M.N.N. delivered her child, the provider forcibly cut her clitoris, causing her extreme physical and mental pain. M.N.N. was horrified and traumatized to discover that she had been genitally mutilated. The mission hospital refused to take her complaints seriously, and doctors at other clinics did not want to get involved. One doctor dismissed her by stating that her private parts were meant to fulfill the desires of men. A women’s hospital that specializes in treating survivors of gender-based violence initially completed a report confirming that M.N.N.’s genitals had been mutilated, but she was later called back to the same facility for a second examination, after which a doctor denied the initial findings and issued a contradicting report. M.N.N. was able to get another report confirming the mutilation from the Langata Police in April 2006, nearly a year after the violation occurred. However, she first had to pay the policewoman’s bus fare so that she would agree to accompany her to the examination as required.

M.N.N. filed a complaint with the body that regulates the healthcare practice in Kenya, but it was dismissed without explanation. She also filed a civil case that has been languishing in court since 2006. The Center and FIDA-Kenya brought a case before Kenya’s High Court (M.N.N. v. Attorney General of Kenya) against the government for its failure to protect patients in private healthcare facilities and to criminalize and prosecute FGM of adult women. The case has been pending since 2008. M.N.N. no longer enjoys sexual intercourse, and her chronic physical pain and mental anguish negatively affect her and her husband. To date, M.N.N. has not received any form of redress for the violations of her reproductive rights.

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1. The High Court of Kenya has jurisdiction to determine whether any rights or fundamental freedoms in the country’s Bill of Rights have been “denied, violated, infringed or threatened.” Constitution, Art. 16(3)(b) (2010) (Kenya).
As this briefing paper illustrates, women and girls face a wide range of reproductive rights violations that may rise to the level of torture or CIDT. Due in part to their gender, sexuality, and reproductive capacity, women and girls are often vulnerable to torture and ill-treatment within healthcare, detention, and other custodial settings.

These abuses are underlined by discrimination, involve tremendous physical and psychological pain, and have devastating effects on women’s and girls’ lives. Notably, human rights bodies at the international, regional, and national levels increasingly recognize that some reproductive rights violations amount to torture or CIDT. This emerging recognition has significant legal implications for the state, since states are obligated to prevent, punish, and redress all forms of torture or CIDT. Recognizing reproductive rights violations as torture or CIDT is a significant step forward in ending impunity for these acts.

It is critical for courts, human rights bodies, advocates, and other key stakeholders to ensure that the torture protection framework is applied in a gender-inclusive manner with a view to strengthening the protection of women and girls from torture and CIDT and addressing the particular challenges they face. There is also a need to further understand the links between reproductive rights and the right to be free from torture and CIDT through fact-finding, litigation, and other strategies. Governments should be held accountable for the severe pain, anguish, and even death that women and girls suffer as a result of the denial of their fundamental reproductive rights.

“Women and girls seeking reproductive healthcare services may experience denial of care due to discrimination, stigma, and negative gender stereotypes.”

Article 4 of the Optional Protocol to the Convention against Torture establishes a place of detention, stating that “deprivation of liberty means any form of detention in which a person is not permitted to leave at will by any judicial, administrative or other authority.” This definition thus includes healthcare facilities, psychiatric institutions, and orphanages, among other settings. Optional Protocol to the Convention against Torture, adopted December 15, 2002, art. 3, 63 I.L.M. 909 (2004) (OPCAT). 1


The Inter-American Court elaborated on state complicity in the form of gender discrimination. Caso González y Otras, supra note 7, paras. 15.


Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted Dec. 10, 1984, arts. 21(1), 12, 14, 17(1) (A.R.S. 3864)), U.N. GAOR, 39th Sess., Supp. No. 51, U.N. Doc. A/39/S/51 (1984), 1465 U.N.T.S. 85 (entered into force June 26, 1987) (hereinafter CAT I), International Covenant on Civil and Political Rights, art. 5(2), (hereinafter CAT II, 1976)), 30, U.N. Doc. A/36/1361 (1966), 999 U.N.T.S. 171 (entered into force March 23, 1976) (hereinafter ICCPR) (“each State Party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and procedures, to ensure that the rights recognized in the present Covenant are given practical effect by adopting such appropriate legislative, administrative or other measures as may be necessary to give effect to the rights recognized in the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant.”


Ximenes Lopes de Brazil, supra note 13.


Given their status in society and the particular impact that laws, policies, and practices have on them.

For example, in the asylum context, coerced sterilization has been found to constitute a form of torture in violation of women’s human rights.


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[“Other obligations aimed at preventing, in particular by means of education and training, by systematically reviewing inclusion of gender-related training in human rights training of judges and public prosecutors.” D. González, Attorney General, 399 F.3d 1195, 2946 (9th Cir. 2005).

CAT, supra note 7, at 1. Certain obligations under the CAT apply only to torture. For example, the obligation to prohibit and criminalize acts of torture and to apply the principle of universal jurisdiction is solely applicable to torture. [“Other obligations aimed at preventing, in particular by means of education and training, by systematically reviewing inclusion of gender-related training in human rights training of judges and public prosecutors.” D. González, Attorney General, 399 F.3d 1195, 2946 (9th Cir. 2005).

CAT, supra note 7, at 4. In a letter addressed to the Permanent Bureau of the UN Human Rights Council, the US Attorney General, 399 F.3d 1195, 2946 (9th Cir. 2005).

CAT Committee, supra note 26, para. 19. The CAT has established three required elements to prove torture: “1) a deliberate action or intentional act; 2) has established three required elements to prove torture: “1) a deliberate action or intentional act; 2) physical or mental pain or suffering; and 3) that such pain or suffering was inflicted in order to obtain information. The Court distinguishes between torture and CIDT according to the ‘intensity of the suffering inflicted.’”

Amnesty International, Comisión Interamericana de Derechos Humanos, supra note 19, para. 30. In the case of Chile v. the Author (2010), para. 15; HRC, supra note 3, arts. 1, 4(2).

35 For example, the Human Rights Committee has confirmed that Article 7 of the ICCPR “clearly protects not only persons arrested by States, but also workers, students and patients in educational and medical institutions.” Human Rights Committee, General Comment No. 20—Protection of All Human Rights 2008, supra note 5, para. 31. The Special Rapporteur has confirmed that Article 1 of the CAT “should be seen as reinforcing—and reinforced by—the Declaration on the Elimination of Violence against Women adopted by the General Assembly in resolution 48/104.”

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37 See, e.g., Amnesty International, HRC, supra note 3, arts. 1, 4(2).

38 For example, the Human Rights Committee has confirmed that Article 7 of the ICCPR “clearly protects not only persons arrested by States, but also workers, students and patients in educational and medical institutions.” Human Rights Committee, General Comment No. 20—Protection of All Human Rights 2008, supra note 5, para. 31. The Special Rapporteur has confirmed that Article 1 of the CAT “should be seen as reinforcing—and reinforced by—the Declaration on the Elimination of Violence against Women adopted by the General Assembly in resolution 48/104.”


40 Id. (expressing concern regarding sexual violence in conflict situations). See, e.g., Harper v. Texas (2010) (holding that the death penalty is a cruel and unusual punishment). See also Roper v. Roper (2005) (holding that the death penalty is a cruel and unusual punishment).


42 O’Connell, supra note 19, para. 15; HRC, supra note 3, arts. 1, 4(2).


REPRODUCTIVE RIGHTS VIOLATIONS AS TORTURE AND CRUEL, INHUMAN, OR DEGRADING TREATMENT OR PUNISHMENT: 36


FREEDOM IN SLOVAKIA (2003), reproductiverights.org/sites/crr.civicactions.net/files/ressources/fi les/lesson.

One provider reported overhearing a nurse tell a woman, “You had sex, you had your excitement. Now you will have bleeding, ulcers!”) See also Conco-

38, para. 22.

Id.

CAT Committee, Nicaragua, supra note 5, para. 21.

Id.

CAT Committee, Nicaragua, supra note 5, para. 16; El Cuarto Fundamentales (2009) [hereinafter El Cuarto].

Id.

Id.

In Human’s Way was written Kenya approved a new constitution which clarifies the country’s law, policies, and regulations on abortion by spelling out that women are able to terminate a pregnancy when it threatens their life or health. Although the previous legal regime permitted abortion to save the pregnant woman’s life, the language was not clearly defined and women and doctors risked imprisonment. See, e.g., Art. 24 (2010) (Kenya).

It is widely accepted that gender violence can constitute violence against women, as well as result in “taking whatever legal and other measures [that] are necessary to effectively prevent acts that put women’s health at grave risk, by providing the required medical treatment, by strengthening family planning and reproductive health services, including information and reproductive health services, including family planning services that impact women’s reproductive rights and contribute to, or constitute violence against women.” (See supra note 36 at 107 (citing to information and reproductive health services, including for adolescents.”).


Slovakia

See, e.g., United Nations, Human Rights Law Network, Report submitted to the magisterial inquiry committee of the death of HIV positive woman at “MY Hospital in Indore (Apr. 7, 2007) on file with the Center)

See, e.g., United Nations, General Comment 28 (2000) [hereinafter UNHCR, Memo on FGM].

See, e.g., Declaration of the International Conference on Population and Development (1994) [hereinafter Programme of Action] (recalling that “the right to health is a fundamental human right, and the enjoyment of this right is essential for the full enjoyment of all other human rights”).

See, e.g., Programme of Action, supra note 24, paras. 6: “Women who undertake an illegal abortion in cases of rape and in cases of a state of shock due to the extreme pain, psychological trauma, and exhaustion, and can result in “death through severe bleeding, heavy infections, hemorrhagic shock, neonatal shock as a result of pain and trauma, and overwhelming infection and sepsisama.” Psychological and physical consequences of FGM may include “increased likelihood of fear of sexual intercourse, post-traumatic stress disorder, infertility, and psycho-social injury loss.”

See, e.g., The Impact of Reproductive Rights on Maternal Mortality in Indonesia, supra note 77, note 5, para. 55 [hereinafter UNHCR, Memo on FGM].

See, e.g., UNHCR, supra note 29, para. 13. An additional study on FGM has noted that “countries that have not approved a constitutional or legal provision to protect against FGM have a higher prevalence of FGM. In some countries, FGM is prohibited by law. The absence of a constitutional or legal provision to protect against FGM in countries that have legislation does not necessarily mean that FGM is not practiced in those countries.”


See, e.g., Declaration of the International Conference on Population and Development (1994) [hereinafter Programme of Action] (recalling that “the right to health is a fundamental human right, and the enjoyment of this right is essential for the full enjoyment of all other human rights”).


See, e.g., Radhika Coomaraswamy, supra note 23, para. 7.

See, e.g., Radhika Coomaraswamy, supra note 23, para. 5.


REPRODUCTIVE RIGHTS VIOLATIONS AS TORTURE AND CRUEL, INHUMAN, OR DEGRADING TREATMENT OR PUNISHMENT: A CRITICAL HUMAN RIGHTS ANALYSIS

138 See, e.g., CAT Committee, Togo, supra note 135, para. 27; Indonesia, supra note 134, para. 16; Kenya, supra note 134, para. 27.
139 See CAT Committee, Australia, supra note 137, para. 43.
140 Id.
141 See CAT Committee, Togo, supra note 135, para. 27; Kenya, supra note 133, para. 27.
142 Special Rapporteur on Torture—Promotion and Protection of All Human Rights, supra note 5, para. 53.
143 Id.
144 See UNHCR, Memo on FGM, supra note 132, para. 7.