BRIEFING PAPER

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

CENTER FOR REPRODUCTIVE RIGHTS

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CENTER FOR REPRODUCTIVE RIGHTS

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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; 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.

INTRODUCTION

TREATY-BASED ANTI-TORTURE AND CIDT PROVISIONS

The UN Convention against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment, the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, and the Inter-American Convention to Prevent and Punish Torture exclusively address eradication of torture and CIDT.

Key international human rights treaties also contain prohibitions of torture and CIDT. Article 7 of the International Covenant on Civil and Political Rights prohibits torture and CIDT.

The Convention on the Rights of Persons with Disabilities, the newest international human rights treaty, contains detailed sexual and reproductive rights protections and prohibitions of torture or CIDT in Articles 15, 23, and 25.

Article 37 of the Convention on the Rights of the Child also establishes the right of children to be free from torture and CIDT.

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 cruel, inhuman, or degrading treatment (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 state's 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.[1] 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.

REGIONAL TREATY-BASED ANTI-TORTURE AND CIDT PROVISIONS

Article 5 of the African Charter on Human and Peoples' Rights calls for respect for human dignity and prohibits exploitation and degradation, listing torture and CIDT as examples of the latter.

Article 4 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa prohibits exploitation and CIDT of women, including all medical or scientific experiments without their informed consent. Article 16(1) of the African Charter on the Rights and Welfare of the Child calls for legislative, administrative, social, and educational measures to protect the child from all forms of torture and inhuman or degrading treatment.

Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms prohibits torture and CIDT, irrespective of the victim's conduct.

Article 5(1) of the American Convention on Human Rights ensures the right to physical, mental, and moral integrity. Violations of this right have been interpreted to encompass "treatment ranging from torture to other types of humiliation or cruel, inhuman or degrading treatment with varying degrees of physical and psychological effects caused by endogenous and exogenous factors which must be proven in each specific situation." (Loayza-Tamayo v. Peru, Inter-Am. Ct. H.R. (ser. C) No. 33, para. 57 (Sept. 17, 1997).

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.[2] 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.[3] 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."[4]

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.[5] 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."[6]

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.[7] 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.[8] 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."[9] 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.[10] (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…."[11] 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."[12] 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/or marginalized individuals from torture, as individuals who face discrimination are generally more at risk of experiencing torture and CIDT.[13] 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.[14] 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…."[15] 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.[16]

International human rights law has long recognized that states have a positive obligation to exercise due diligence in securing the enjoyment of human rights.[17] 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.[18] 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.[19] 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.[20]

The CAT Committee has highlighted that gender intersects with "race, nationality, religion, sexual orientation, age, [and] immigrant status," among other characteristics, to determine the ways in which women and girls are vulnerable to torture or ill-treatment and the consequences of this vulnerability. The Committee has stated that women are particularly at risk in contexts of "deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence by private actors in communities and homes."[1]

[1] Committee against Torture, *General Comment No. 2: Implementation of article 2 by States parties*, para. 15, U.N. Doc. CAT/C/GC/2 (2008).

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.[2] 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.[3] 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.[4]

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Professional ethical standards permit the subordination of loyalty to one's patient only to serve a higher social purpose.[5] Discriminatory practices that violate human rights do not constitute a valid higher purpose and violate healthcare providers' ethical and human rights obligations.[6] 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.[7] 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.[8] States should ensure that legislative and policy frameworks promote, rather than compromise, the realization of human rights in the healthcare setting.[9]

1 World Medical Association (WMA), *International Code of Medical Ethics: Declaration of Geneva, Adopted by the 3rd General Assembly of the WMA*, London, England, Oct. 1949 (as amended in 1968, 1983, and 2006), *available at* http://www.wma.net/en/30publications/10policies/c8/index.html.
2 International Dual Loyalty Working Group, Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms 12 (2002).
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*.[21] 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.[22] 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, which are particularly vulnerable when a person is undergoing health treatment."[23] The Court confirmed that states are responsible for regulating and monitoring the delivery of health services in order to achieve the effective protection 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 and 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.[24] 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.[25]

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

A gender analysis[26] 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);[27] 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.[28]

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.[29] International standards do, however, provide some guidance on the elements that comprise cruel, inhuman, and degrading treatment.[30] Similar to torture, cruel and inhuman treatment, as defined in the CAT, requires evidence of severe pain or suffering.[31] 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.[32] 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.[33] 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,[34] and the Special Rapporteur on Torture has asserted that CIDT can be either intentional or negligent and with or without a specific purpose.[35] 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.[36]

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."[37] 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.[38] 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,[39] and the Court generally distinguishes between torture and CIDT based on the force of violence, severity of pain, and suffering inflicted.[40] 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' behaviour perceived as non-consonant with gender roles and stereotypes or at asserting or perpetuating male domination over women."[41] For example, legal and policy restrictions on abortion and contraception have the discriminatory purpose and effect of denying women services that only they need[42] 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 immense physical and psychological abuse.[50] The Court found that the forced nudity was particularly grave for the women who were subjected to it[51] 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."[52] 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).[53] 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)[54] 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)).[55]

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.[56] 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.[57] 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."[58]

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."[59] 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."[60] 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.[61]

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.[62] 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."[63] Thus, the

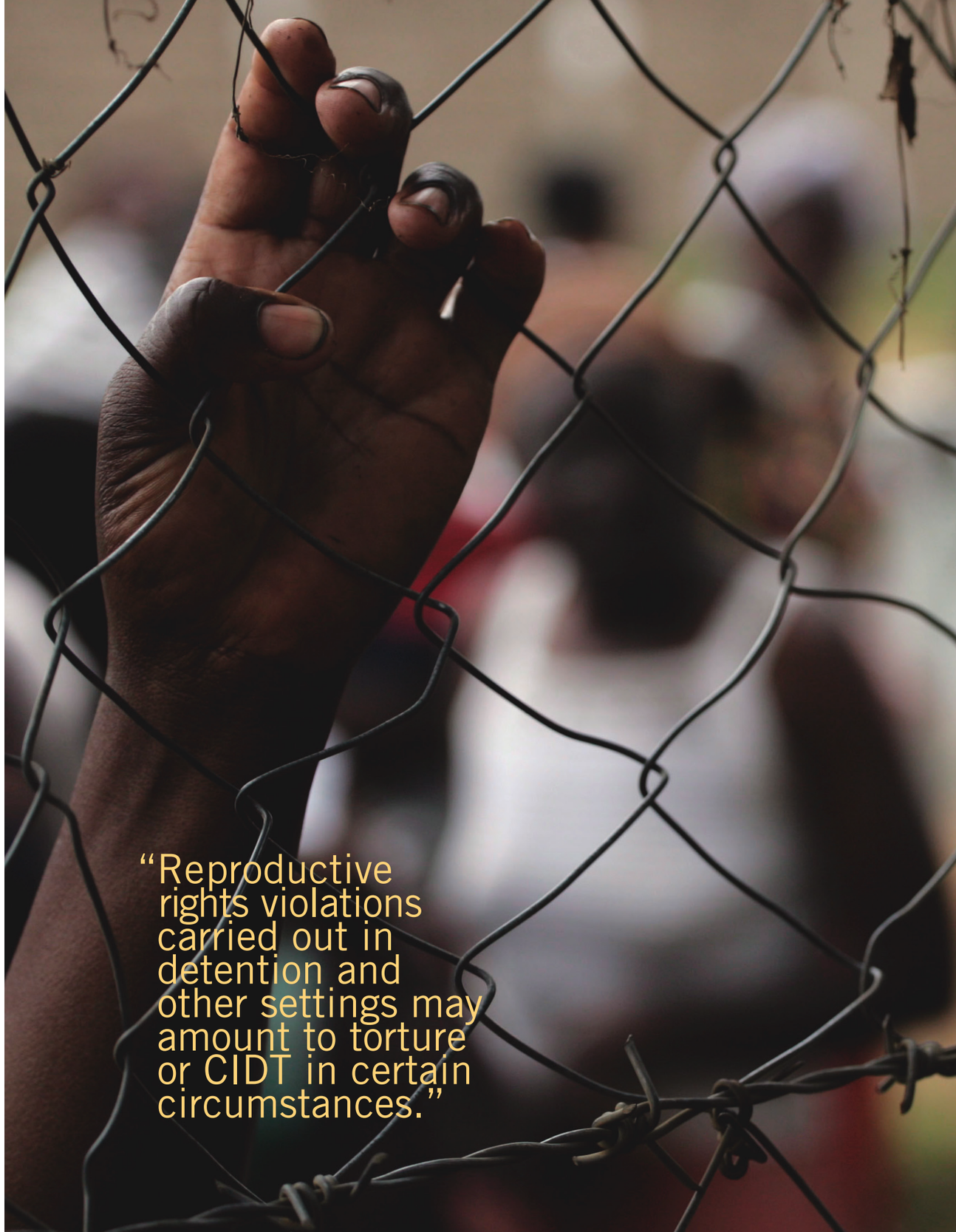
protection extends to both public and private educational settings, for example, where girls are subjected to sexual violence at the hands of teachers and administrators who exercise control and authority over them.[64]

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]



EVOLVING LEGAL STANDARDS OF REPRODUCTIVE RIGHTS VIOLATIONS AS TORTURE OR CIDT

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."[74]

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 torture or 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.[75] 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—infringes upon women's physical and psychological integrity, arguably violating the right to be free from CIDT.[76] 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.[77] 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.[78]

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.[79] 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.[80]

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."[81] The Committee called upon the government to ensure that the "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."[82]

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*,[83] 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.

Coercive Sterilization of an HIV-Positive Woman: F.S. v. Chile

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.[84] 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.[86] Moreover, human rights bodies and experts have repeatedly emphasized the need to obtain informed consent for sterilization procedures.[87] 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."[88]

In recent years, the CAT Committee has explicitly addressed coercive sterilization in its concluding observations. For example, the Committee expressed concern to the governments of the Czech Republic and Slovakia regarding "involuntary sterilizations of Roma women"[89] and called upon the states to investigate these claims.[90] The Committee called upon the Slovak government to "prosecute and punish the perpetrators and provide the victims with fair and adequate compensation."[91] 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."[92] The Committee also issued concluding observations to Peru that expressed concern about the practice of coerced 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."[93]

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.[94] 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…."[95]

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 tortue or CIDT.

Access to Abortion

International and regional human rights bodies have increasingly recognized that restrictive abortion laws violate women's human rights.[96] Moreover, they have affirmed that in cases where abortion is legal, it needs to be accessible.[97] However, women are often denied access to abortion arguably 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.[98] 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."[1]

[1] K.L. v. Peru, Communication No. 1153/2003, Human Rights Committee, para. 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

T. did eventually receive an abortion in the final days of her twelfth week of pregnancy, clandestinely, in a hospital more than 400 kilometers from her home. In 2008, the Center and the Federation for Women and Family Planning (Poland) filed a complaint with the European Court arguing that the temporary removal of T. from her mother's custody, unregulated conscientious objection, biased and unlawful "counseling," the coercive hospital stay, breach of confidentiality, and presence of unauthorized persons on hospital grounds violated T.'s human rights.

The CAT Committee has repeatedly expressed concern about laws that restrict or ban access to abortion. The Committee noted in its concluding observations to Peru that the state's restrictive abortion law "severely restricts access to voluntary abortion, even in cases of rape, leading to grave consequences, including the unnecessary deaths of women."[99] The Committee also expressed concern that the Peruvian government had failed to prevent acts that put women's physical and mental health at grave risk and that constitute cruel and inhuman treatment,[100] and called upon the Peruvian government to "take whatever legal and other measures are necessary to effectively prevent acts that put women's health at grave risk, by providing the required medical treatment…."[101] The Committee has also expressed concern about the absolute bans on abortion in Nicaragua and El Salvador and noted the grave consequences the legislation poses to women's lives and health.[102] The Committee called upon the government of Nicaragua to review its restrictive legislation with an eye toward providing exceptions to the ban in cases where the pregnancy was the result of rape or incest.[103] The Committee also recommended that the government of El Salvador "take whatever legal or other measures are necessary to effectively prevent, investigate and punish crimes and all acts that put the health of women and girls at grave risk, by providing the required medical treatment."[104]

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.[105] 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.[106] 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.*[107] 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."[108] 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.[109] The Committee issued the same recommendation to the Nicaraguan government in response to its absolute ban on abortion.[110]

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.[111] 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.[112]

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.[113] 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.[114]

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.

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 informed 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. Despite 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.

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]

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]

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 pregnant women during labor had been clearly established by the U.S. Supreme Court and the lower courts.[2] Soon thereafter, on July 16, 2010, a jury found that Nelson's Eighth Amendment rights had been violated.

1 Nelson v. Corr. Med. Serv., 583 F.3d 522, 4 (8th Cir. 2009).
2 *Id.* at 17-18.

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 found that the act constituted torture."[120] 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."[121]

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 women[122] 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. Ecuador*.[126] 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 phosphorus. 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 Ecuadorean 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 Ecuadorean 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 Ecuadorean government has yet to provide Paola's parents any redress for the loss of their daughter.[128]

FEMALE GENITAL MUTILATION

FGM has extreme physical and psychological consequences for women and girls,[129] with the pain and trauma inflicted by it often continuing beyond the actual procedure.[130] The HRC has deemed FGM a violation of the right to be free from torture and CIDT under the ICCPR.[131] 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.[132]

The CAT Committee has generally addressed FGM within its interpretations of Article 16 of the CAT, which calls for the prevention of CIDT.[133] In one instance, the Committee explicitly referenced FGM as a traditional practice that "violate[s] the physical integrity and human dignity of women and girls" and constitutes CIDT.[134] The Committee has commended states for passing legislation banning FGM,[135] expressed concern regarding the lack of such legislation,[136] and recommended the passage of such legislation.[137] The Committee has also recommended the implementation of nationwide education and awareness campaigns[138] and investigation,[139] prosecution,[140] and punishment of perpetrators of FGM[141] 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.[142] 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.[143] The UN Office of the High Commissioner for Refugees takes the position that a state's toleration of FGM and/or unwillingness to provide protection from FGM is equivalent to state acquiescence to the practice.[144]

FGM in Healthcare Facilities: M.N.N. v. Attorney General of Kenya

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[1] (*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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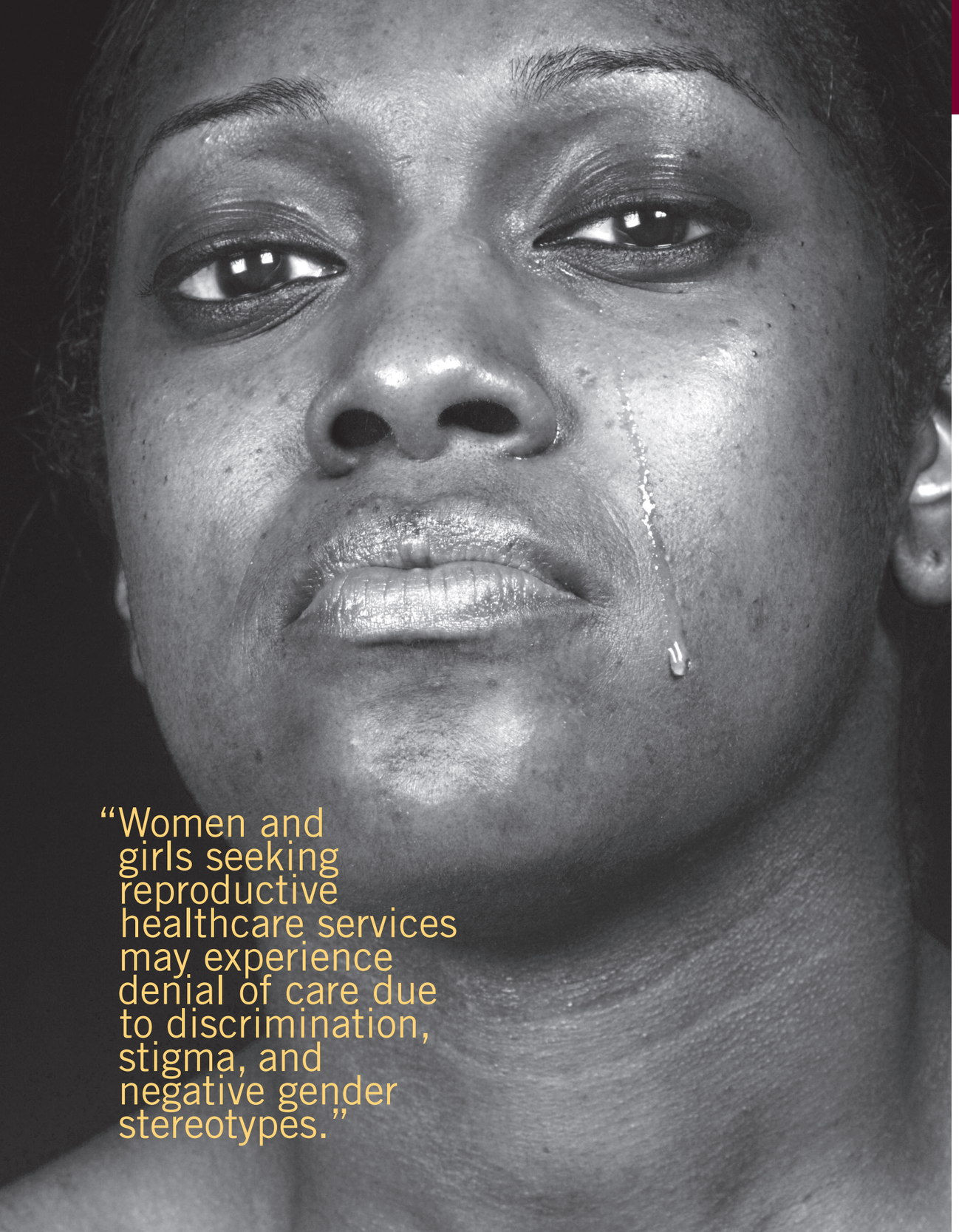
[1] The High Court of Kenya has jurisdiction to determine whether any rights or fundamental freedoms in the country's Bill of Rights have been "denied, violated, infringed or threatened." CONSTITUTION, Art. 165(3)(b) (2010) (Kenya).



CONCLUSION

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.

ENDNOTES

1 This briefing paper does not intend to be an exhaustive analysis of all sexual and reproductive rights violations that can rise to the level of torture or CIDT. Instead, its intention is to provide a legal analysis of how certain violations can be regarded as torture or CIDT and illustrate this argument through concrete examples based on the Center's work. For more on the work that NGOs are doing in this area see: Memorandum from Matthew Goodro, Law and Health Initiative, Open Society Institute to Jonathan Cohen and Tamar Ezer, Law and Health Initiative, Open Society Institute, *Health Care and the Prohibition Against Torture and Cruel, Inhuman, and Degrading Treatment or Punishment* 7-8 (May 12, 2009) (on file with the Center) [hereinafter *OSI—Health Care and the Prohibition Against Torture*]; Joseph Amon, *Abusing Patients: Health Providers' Complicity in Torture and Cruel, Inhuman or Degrading Treatment*, *in* Human Rights Watch, World Report 49, 54 (2010), *available at* http://www.hrw.org/en/node/87624 [hereinafter *Abusing Patients*].

2 The prohibition of torture is regarded as norm of *jus cogens* (norm of universal application). Under international law, *jus cogens* norms are peremptory and non-derogable. *See* Vienna Convention on the Law of Treaties art. 53, May 23, 1969, 1155 U.N.T.S. 331. Jurisprudence at the national and international levels has confirmed that acts of torture constitute *jus cogens* violations. *See, e.g.,* Siderman de Blake v. Republic of Argentina, 965 F.2d 699 (9th Cir. 1992) (U.S.); *see also* Prosecutor v. Furundzija, Case No. IT-95-17/1-T, International Criminal Tribunal for the Former Yugoslavia, Judgment (Dec. 10, 1998).

3 Article 4 of the Optional Protocol to the Convention against Torture broadly defines a place of detention, stating that "deprivation of liberty means 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." This definition thus includes healthcare facilities, psychiatric institutions, and orphanages, among other settings. Optional Protocol to the Convention against Torture, *adopted* Dec. 18, 2002, art. 4, G.A. Res. A/RES/57/199, 57th Sess., U.N. Doc. A/RES/57/199 (2003) [hereinafter OP-CAT].

4 Committee against Torture, *General Comment No. 2: Implementation of article 2 by States parties*, para. 15, U.N. Doc. CAT/C/GC/2 (2008) [hereinafter CAT Committee, *General Comment 2*].

5 *See, e.g.,* Committee against Torture, *Concluding Observations: Chile*, para. 7(m), U.N. Doc. CAT/C/CR/32/5 (2004) [hereinafter CAT Committee, *Chile*]; *El Salvador*, para. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009) [hereinafter CAT Committee, *El Salvador*]; *Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009) [hereinafter CAT Committee, *Nicaragua*]; *Peru*, para. 23, U.N. Doc. CAT/C/PER/CO/4 (2006) [hereinafter CAT Committee, *Peru*]; *see also* Manfred Nowak, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development,* (7th Sess.), U.N. Doc. A/HRC/7/3 (2008) [hereinafter *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*]; Human Rights Committee, *General Comment No. 28: Equality of Rights between Men and Women (Art. 3)*, (68th Sess., 2000), *in* Compilation of General Comments and Recommendations by Human Rights Treaty Bodies, at 228, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter HRC, *General Comment 28*] (establishing that violations of article 7 on the right to be free from torture and CIDT include forced abortion as well as denial of access to safe abortion for women who have become pregnant as a result of rape).

6 *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 26.

7 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, arts. 2(1), 12, 14, G.A. Res. 39/46, UN GAOR, 39th Sess., Supp. No. 51, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987) [hereinafter CAT]; International Covenant on Civil and Political Rights, art. 2(2), G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR] ("each State Party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and with the provisions of 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"); Human Rights Committee, *General Comment No. 20 (Art. 7)*, (44th Sess., 1992), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 200, para. 8, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. 1) (2008) [hereinafter HRC*, General Comment 20*]; African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, arts. 1, 5, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986); Godínez-Cruz v. Honduras, 1989 Inter-Am. Ct. H.R. (ser. C) No. 5, para. 175 (Jan. 20, 1989) (finding that states must prevent, investigate, and punish any violations of the rights recognized by the American Convention on Human Rights, attempt to restore the violated right, and provide compensation for damages); Velásquez-Rodríguez v. Honduras, 1988 Inter-Am. Ct. H.R. (ser. C) No. 4, para. 166 (July 28, 1988) (finding that the obligation to "ensure" the "free and full exercise of rights" recognized by the American Convention requires states to prevent, investigate, and punish any violations of the rights recognized by the Convention, attempt to restore the violated right, and provide compensation for damages). Notably, the CAT specifically calls upon states to criminalize all acts and attempted acts of torture, as well as complicity with or participation in such acts. *See* CAT, *supra* note 7, art. 4.

8 *See* CAT, *supra* note 7, art. 10; *see also* Interights, Prohibition of Torture and Inhuman or Degrading Treatment or Punishment under the European Convention on Human Rights (Article 3) 54 (2006), *available at* http://www.interights.org/view-document/index.htm?id=242.

9 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 4(d) [hereinafter Maputo Protocol].

10 *See* CAT, *supra* note 7, art. 12; *see also* Godínez-Cruz v. Honduras, *supra* note 7, para. 175; Velásquez-Rodríguez v. Honduras, *supra* note 7, para. 166; M.C. v. Bulgaria, App. No. 39272/98 , Eur. Ct. H.R., para. 151-53 (2004).

11 CAT Committee, *General Comment 2*, *supra* note 4, para. 3.

12 *Id.* para. 4.

13 *Id.* para. 21 (referencing the following statuses as pertinent to the application of the principle of non-discrimination in the context of torture and CIDT analysis: "race, colour, ethnicity, age, religious belief or affiliation, political or other opinion, national or social origin, gender, sexual orientation, transgender identity, mental or other disability, health status, economic or indigenous status, reason for which the person is detained, including persons accused of political offences or terrorist acts, asylum-seekers, refugees or others under international protection, or any other status or adverse distinction"); *see also* Ximenes Lopes v. Brazil, 2006 Inter-Am. Ct. H.R. (ser. C) No. 149, para. 103 (July 4, 2006).

14 *See* CAT Committee, *General Comment 2*, *supra* note 4, para. 15.

15 *Id.* para. 17.

16 *See* Ximenes Lopes v. Brazil, *supra* note 13, paras. 85-86.

17 *See* Yakin Ertürk, *Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women: The Due Diligence Standard As A Tool for the Elimination of Violence Against Women*, U.N. Doc. E/CN.4/2006/61 (2006) (analyzing the due diligence standard and its application to violations of women's human rights).

18 The Inter-American Court elaborated on state responsibility for violence against women by non-state actors in *Caso González y Otras ("Campo Algondero") v. México*. This case involved a series of hundreds of unsolved and poorly investigated disappearances, rapes, and murders of young women and migrant girls in Ciudad Juarez over the past 15 years. The Court found that the Mexican government had violated its due diligence obligations, confirmed that state inaction and indifference to the violence amidst its purported investigation of the cases essentially condoned and reinforced the violence against women, and concluded that the violence at issue in the case was clearly a form of gender discrimination. Caso González y Otras ("Campo Algondero") v. México, 2009 Inter-Am. Ct. H.R. (ser. C) No. 205 (Nov. 16, 2009).

19 *See* Frans Viljoen & Chidi Odinkalu, World Organization Against Torture (OMCT), The Prohibition of Torture and Ill-Treatment in the African Human Rights System: A Handbook for Victims and their Advocates, 55 (OMCT Handbook Series Vol. 3, Boris Wijkström ed., 2006) [hereinafter OMCT, Torture and Ill-Treatment in the African Human Rights System Handbook] (citing the African Charter on the Rights and Welfare of the Child, *adopted by* the Assembly of Heads of State and Government of the OAU, Kampala, Uganda, 1990, AU Doc. CAB/LEG/24.9/49 (*entered into force* Nov. 29, 1999), arts. 1(3), 10, 15, 16, 19(1), 20-21.

20 Maputo Protocol, *supra* note 9, art. 4. Notably, the Supreme Court of Nigeria has also confirmed that the prohibition against slavery and other forms of inhuman and degrading punishment or treatment is not limited to state acts, but also extends to private acts. *See* Uzoukwu v. Ezeonu II, 6 Nigeria Weekly Law Reports (Pt. 200) 708 (1991).

21 Ximenes Lopes v. Brazil, *supra* note 13.

22 *Id.* para. 150.

23 *Id.* para. 89.

24 *See* Committee on the Elimination of Discrimination Against Women, *General Recommendation No. 19: Violence against women,* para. 9, U.N. Doc. A/47/38 (1993) [hereinafter CEDAW Committee*, General Recommendation 19*]; *see also* Velásquez-Rodríguez v. Honduras, *supra* note 7, paras. 79, 172; M.C. v. Bulgaria, *supra* note 10, paras. 148-166. The CAT Committee has noted that "[s]ince the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity, the State's indifference or inaction provides a form of encouragement and/or de facto permission." CAT Committee, *General Comment 2*, *supra* note 4, para.18.

25 *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 68; *see also* CAT Committee, *General Comment 2*, *supra* note 4, para. 18.

26 For the purpose of this briefing paper, when we refer to gender analysis we mean the examination of the specific risks and conditions experienced by women given their status in society and the particular impact that laws, policies, and practices have on them.

27 For example, in the asylum context, coerced sterilization has been found to constitute a "permanent and ongoing form of persecution." Matter of Y-T-L, 32 I&N Dec. 601 (BIA 2003), *available at* http://www.usdoj.gov/eoir/vll/intdec/vol23/3492.pdf. It has also been deemed that forced sterilization "involves drastic and emotionally painful consequences that are unending…." Qu v. Gonzales, Attorney General, 399 F.3d 1195, 2946 (9th Cir. 2005).

28 CAT, *supra* note 7, art. 1. Certain obligations under the CAT apply only to torture. For example, the obligation to criminalize acts of torture and to apply the principle of universal jurisdiction is solely applicable to torture. "[O]ther obligations aimed at prevention, in particular by means of education and training, by systematically reviewing interrogation rules and practices, by ensuring a prompt and impartial ex officio investigation, and by ensuring an effective complaints mechanism, as laid

down in articles 10 to 13, must be equally applied to other forms of ill-treatment as well…." Manfred Nowak, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Civil and Political Rights, Including Questions of Torture and Detention*, (62nd Sess.), para. 37, U.N. Doc. E/CN.4/2006/6 (2005) [hereinafter *Special Rapporteur on Torture—Civil and Political Rights 2005*].

29 CAT, *supra* note 7, art. 16.

30 There is still some debate at the international level regarding the distinction between torture and CIDT. For instance, the U.N. Special Rapporteur on Torture states that cruel and inhuman treatment should not be distinguished from torture based on the intensity of the suffering but rather based on the purpose of the conduct and the powerlessness of the victim. This differs from the view of the European Court of Human Rights, which stated in its decision in *Ireland v. United Kingdom* that the distinction between torture and CIDT derives principally from the difference in the "intensity of the suffering inflicted." *Report of the Special Rapporteur on Torture—Civil and Political Rights 2005*, *supra* note 28, para. 39; Ireland v. United Kingdom, App. No. 5310/71, Eur. Ct. H.R., para. 167 (1978).

31 *See OSI—Health Care and the Prohibition Against Torture*, *supra* note 1, at 7-8. Prohibitions of torture and CIDT are non-derogable under both the ICCPR and the CAT, which does not permit derogation for any of its provisions. *See Special Rapporteur on Torture—Civil and Political Rights 2005*, *supra* note 28, para. 36 (citing ICCPR Article 7 (concerning torture and CIDT) and Article 4(2) (concerning derogation during states of emergency)).

32 *Special Rapporteur on Torture—Civil and Political Rights 2005*, *supra* note 28, para. 35.

33 *See OSI—Health Care and the Prohibition Against Torture*, *supra* note 1, at 9.

34 CAT Committee, *General Comment 2*, *supra* note 4, para. 10.

35 *Special Rapporteur on Torture—Civil and Political Rights 2005*, *supra* note 28, para. 35.

36 The jurisprudence within the Inter-American system has established three required elements to prove torture: "1) a deliberate action or intentional act; 2) severe physical or mental pain or anguish suffered by the victim; and 3) a purpose to perpetrate the torture." Article 2 of the Inter-American Convention to Prevent and Punish Torture (Inter-American Torture Convention) does not explicitly require a showing of severe pain or suffering to constitute torture. However, a requirement has emerged within Inter-American case law that, in order to constitute torture, the pain or suffering inflicted must be severe or intense. Case law does not yet provide clear guidance as to what qualifies as "severe." Diego Rodríguez-Pinzón & Claudia Martin, World Organization Against Torture (OMCT), The Prohibition of Torture and Ill-Treatment in the Inter-American Human Rights System: A Handbook for Victims and their Advocates 106, n. 303 (OMCT Handbook Series Vol. 2, Boris Wijkström ed., 2006) (citing Caesar v. Trinidad and Tobago, Inter-Am Ct. H.R. (ser. C) No. 123, para. 50 (Mar. 11, 2005); Luis Lizardo Cabrera v. Dominican Republic, Case 10.832, Inter-Am. C.H.R., Report No. 35/96, OEA/Ser.L/V/II.98 Doc. 6 rev., para. 85 (1997)) [hereinafter OMCT, Prohibition of Torture and Ill-Treatment in the Inter-American System].

The European Court has ascribed in part to the CAT's definition of torture to extract three essential elements, which if met, constitute torture: 1) infliction of severe mental pain or suffering; 2) intentional or deliberate infliction of pain; and 3) pursuit of a specific purpose, such as intimidation or punishment, or obtaining information. The Court distinguishes between torture and other types of ill-treatment according to the "intensity of the suffering inflicted." Aisling Reidy, Council of Europe, The Prohibition of Torture: A Guide to the Implementation of Article 3 of the European Convention on Human Rights 12 (Human Rights Handbooks, No. 6, 2002), *available at* http://echr.coe.int/NR/rdonlyres/0B190136-F756-4679-93EC-42EEBEAD50C3/0/DG2ENHRHAND062003.pdf [hereinafter COE, Prohibition of Torture Handbook].

37 CAT Committee, *General Comment 2*, *supra* note 4, para. 3 (the Committee against Torture generally uses the term "ill-treatment" in place of cruel, inhuman, or degrading treatment or punishment).

38 The CAT Committee has emphasized that ill-treatment is often conducive to torture and that torture and CIDT are therefore closely intertwined. *See Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 33. Similar to other human rights bodies and tribunals, the African Commission generally fails to distinguish between a failure to respect dignity and a CIDT violation when finding Article 5 violations. The Commission's conflation of the Article 5 protections has been attributed to two primary factors: 1) facts presented to the Commission tend to be imprecise and cumulative, yet clearly demonstrative of excessive ill-treatment or punishment, thus not requiring in-depth judicial analysis and 2) a judicial trend of limited discussion and analysis of claims brought to the Commission. *See, e.g.,* Amnesty International, Comité Loosli Bachelard, Lawyers Committee for Human Rights and Association of Members of the Episcopal Conference of East Africa v. Sudan, Comm. No. 48/90, 50/91, 52/91, 89/93, Thirteenth Activity Report (2000) AHRLR 297 (ACHPR 1999); *see also* OMCT, Torture and Ill-Treatment in the African Human Rights System Handbook, *supra* note 19, at 38-39.

39 *See* COE, Prohibition of Torture Handbook, *supra* note 36, at 11. The European Court has also confirmed that torture is distinguishable as "an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment." Additionally, "[a]cts which objectively inflict sufficient severity of pain" are considered torture, regardless of the subjective factors. *See id.* at 12 (citing Selmouni v. France, App. No. 25803/94, Eur. Ct. H.R. (1999)).

40 *See* Ireland v. United Kingdom, *supra* note 30, para. 167 ("The distinction between torture and inhuman treatment derives principally from a difference in the intensity of the suffering inflicted."); *see also* Tyrer v. United Kingdom, App. No. 5856/72, Eur. Ct. H.R., paras. 29-30 (1978) ("The Court does not consider that the facts of this particular case reveal that the applicant underwent suffering of the level inherent in [the notion of torture] as it was interpreted and applied by the Court in its judgment [of Ireland v. United Kingdom]…. in order for a punishment to be "degrading" and in breach of Article 3 (art. 3), the humiliation or debasement involved must attain a particular level…. The assessment is, in the nature of things, relative: it depends on all the circumstances of the case and, in particular, on the nature and context of the punishment itself and the manner and method of its execution."); Selmouni v. France, *supra* note 39, para. 96 ("In order to determine whether a particular form of ill-treatment should be qualified as torture, the Court must have regard to the distinction, embodied in Article 3, between this notion and that of inhuman or degrading treatment. As the European Court has previously found, it appears that it was the intention that the Convention should, by means of this distinction, attach a special stigma to deliberate inhuman treatment causing very serious and cruel suffering.").

41 *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, at 7, n. 7.

42 Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Women and Health (Article 12)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 362, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *General Recommendation 24*].

43 *See* Rebecca J. Cook & Simone Cusack, Gender Stereotyping: Transnational Legal Perspectives 85 (2009).

44 *See Abusing Patients*, *supra* note 1, at 49, 54.

45 *See* Office of the High Commissioner for Human Rights, Expert Seminar on Freedom from Torture and Ill Treatment and Persons with Disabilities 5 (2007), *available at* http://www2.ohchr.org/english/issues/disability/torture.htm.

46 *Report of the Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 30. The Special Rapporteur defined "gender-specific" violence as violence aimed at "correcting" behavior perceived as non-consonant with gender roles and stereotypes or at asserting or perpetuating male domination over women. *See id.* n. 7.

47 *Id.* para. 30.

48 *See* COE, Prohibition of Torture Handbook, *supra* note 36, at 12; *see also* Huri-Laws v. Nigeria, Comm. No. 225/98, Fourteenth Activity Report, AHRLR 273 (ACHPR 2000), para. 41; OMCT, Torture and Ill-Treatment in the African Human Rights System Handbook, *supra* note 19, at 40-41; OMCT, Prohibition of Torture and Ill-Treatment in the Inter-American System, *supra* note 36, at 108 (citing Gómez-Paquiyauri Brothers v. Peru, Inter-Am. Ct. H.R. (ser. C) No. 110, para. 113 (July 8, 2004)).

49 *See* Children´s Rehabilitation v. Paraguay, Inter-Am. Ct. H.R. (ser. C) No. 112, para. 162 (Sept. 2, 2004); *see also* Gómez-Paquiyauri Brothers v. Peru, *supra* note 48, para. 117; Bulacio v. Argentina, Inter-Am. Ct. H.R. (ser. C) No. 100, para. 98 (Sept. 18, 2003); Jailton Neri Da Fonseca v. Brazil, Case 11.634, Inter-Am. C.H.R., Report No. 33/04, OEA/Ser.L/V/II.122 Doc. 5 rev. 1, para. 64 (2004); Víctor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. C.H.R., Report No. 63/99, OEA/Ser.L/V/II.95 Doc. 7 rev., para. 58 (1998).

50 Miguel Castro-Castro Prison v. Peru, Inter-Am. Ct. H.R. (ser. C) No. 160 (Nov. 25, 2006) [hereinafter Miguel Castro-Castro Prison v. Peru]. In a concurrence, Judge A.A. Cançado Trindade explicitly called for and outlined the importance of conducting a gendered analysis of the alleged violations. Miguel Castro-Castro Prison v. Peru, Inter-Am. Ct. H.R. (ser C) No. 160, paras. 58-74 (Nov. 25, 2006) (Cançado Trindade, J., concurring).

51 Miguel Castro-Castro Prison v. Peru, *supra* note 50, at 115, para. 306.

52 *Id.* at 116, para. 308.

53 *Id.* at 166, paras. 4-5.

54 *Id.* at 166, para. 6.

55 *Id.* at 124, para. 344.

56 *See* CAT Committee, *General Comment 2*, *supra* note 4, para. 15.

57 *Id.* para. 18 ("Since the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity, the State's indifference or inaction provides a form of encouragement and/or de facto permission.").

58 *Special Rapporteur on Torture—Promotion and 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.").

59 For example, the Human Rights Committee has confirmed that Article 7 of the ICCPR "clearly protects not only persons arrested or imprisoned, but also pupils and patients in educational and medical institutions." Human Rights Committee, *General Comment No. 7: Prohibition of torture or cruel, inhuman, or degrading treatment or punishment (Art 7)*, (16th Sess., 1982), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 178, para. 2, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. 1) (2008). The HRC's General Comment 20 subsequently replaced General Comment 7 to further develop interpretations of Article 7. To that end, General Comment 20 reaffirms that Article 7 "protects, in particular, children, pupils and patients in teaching and medical institutions." HRC, *General Comment 20*, *supra* note 7, para. 5.

60 OP-CAT, *supra* note 3, arts. 1, 4(2).

61 *See* Center for Reproductive Rights & Federation of Women Lawyers–Kenya, Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities 56-59 (2007), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf [hereinafter Failure to Deliver].

62 CAT Committee, *General Comment 2*, *supra* note 4, para. 15; HRC, *General Comment 20*, *supra* note 7, para. 5.

63 CAT Committee, *General Comment 2*, *supra* note 4, para. 15.

64 *See* CAT Committee, *Concluding Observations: Ecuador*, para. 18, U.N. Doc. CAT/C/ECU/CO/4-6 (2010) (expressing concern regarding sexual violence against girls in schools, particularly when the aggressor is a teacher).

65 CAT Committee, *General Comment 2, supra* note 4, para. 22.

66 *Id.*

[67] *See* Center for Reproductive Rights, In Harm's Way: The Impact of Kenya's Restrictive Abortion Law 14 (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/InHarmsWay_2010.pdf [hereinafter In Harm's Way] ("Women and providers interviewed for this report often raised the issue of the harassment of post-abortion care patients by providers. One provider reported overhearing a nurse tell a woman, 'You had sex, you had your excitement. Now you're crying, who will help you?'"); *see also* Center for Reproductive Rights, Forsaken Lives: The Harmful Impact of the Philippine Criminal Abortion Ban 16 (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/phil_report_Spreads.pdf [hereinafter Forsaken Lives] ("…women who seek post-abortion care [in the Philippines] are frequently harassed, intimidated, abused, and threatened with criminal prosecution by health service providers.… Several women described how providers deliberately delayed care in their cases in order to 'teach them a lesson.'").

[68] *Special Rapporteur on Torture—Civil and Political Rights 2005*, *supra* note 28, para. 40.

[69] *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 28.

[70] *Special Rapporteur on Torture—Civil and Political Rights 2005*, *supra* note 28, para. 40.

[71] *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 52.

[72] Miguel Castro-Castro Prison v. Peru, *supra* note 50, at 115, para. 307.

[73] *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 29.

[74] *See* OMCT, Prohibition of Torture and Ill-Treatment in the Inter-American System, *supra* note 36, at 107 (citing Cantoral-Benavides v. Peru, Inter-Am. Ct. H.R. (ser. C) No. 69, para. 99 (Aug. 18, 2000) (referring to Selmouni v. France, *supra* note 39, para. 101)).

[75] Failure to Deliver, *supra* note 61.

[76] *Id.* at 81.

[77] *Id.* at 28-29, 33-34.

[78] *Id.* at 56-59.

[79] Petition, M.M. v. Peru, Case 12.041, Inter-Am. C.H.R. (1998) (on file with the Center) [hereinafter M.M. v. Peru – Petition].

[80] *Id.* (the petition further alleged that the Peruvian government denied M.M. the right to a full investigation of her complaint and to a trial by an impartial court within a reasonable time period).

[81] CAT Committee, *Concluding Observations: Austria*, para. 22, U.N. Doc. CAT/C/AUT/CO/4-5 (2010) [hereinafter CAT Committee, *Austria*].

[82] *Id.*

[83] Center for Reproductive Rights, Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia (2003), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/bo_slov_part1.pdf.

[84] *See* Steven G. Gabbe et. al., Obstetrics: Normal and Problem Pregnancies 704 (1996).

[85] HRC, *General Comment 28*, *supra* note 5, para. 20.

[86] CEDAW Committee, *General Recommendation 24*, *supra* note 42, para. 22.

[87] *See, e.g.,* Human Rights Committee, *Concluding Observations: Czech Republic*, para. 10, U.N. Doc. CCPR/C/CZE/CO/2 (2007); *Slovakia*, para. 12, U.N. Doc. CCPR/CO/78/SVK (2003); *Peru*, para. 21, U.N. Doc. CCPR/CO/70/PER (2000); CEDAW Committee, *Concluding Observations: Czech Republic*, paras. 23-24, U.N. Doc. CEDAW/C/CZE/CO/3 (2006); *Hungary*, paras. 8-9, U.N. Doc. CEDAW/C/HUN/CO/6 (2007); *Peru*, paras. 484-85, U.N. Doc. A/57/38, Supp. No. 38 (2002); CAT Committee, *Concluding Observations: Czech Republic*, paras. 5(k), 6(n), U.N. Doc. CAT/C/CR/32/2 (2004) [hereinafter CAT Committee, *Czech Republic*]; *Peru*, *supra* note 5, para. 23; Committee on the Elimination of Racial Discrimination, *Concluding Observations: Czech Republic*, para. 14, U.N. Doc. CERD/C/CZE/CO/7 (2007); *Slovakia*, para. 12, U.N. Doc. CERD/C/65/CO/7 (2004).

[88] Radhika Coomaraswamy, *Report of the Special Rapporteur on Violence against Women, its Causes and Consequences: Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women,* (55th Sess.), para. 51, U.N. Doc. E/CN.4/1999/68/Add.4 (1999).

[89] CAT Committee, *Czech Republic*, *supra* note 87, para. 5(k); *Slovakia*, para. 14, U.N. Doc. CAT/C/SVK/CO/2 (2009) [hereinafter CAT Committee, *Slovakia*].

[90] CAT Committee, *Czech Republic*, *supra* note 87, para. 6(n); *Slovakia*, *supra* note 89, para. 14.

[91] CAT Committee, *Slovakia*, *supra* note 89, para. 14.

[92] *Id.*

[93] CAT Committee, *Peru*, *supra* note 5, para. 23 (The Committee also called on the Peruvian government to "take 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 programmes and by offering better access to information and reproductive health services, including for adolescents.").

[94] *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 38; *see also* Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, G.A. Res. 61/106, arts. 12(4), 23(1(b-c)), U.N. Doc. A/RES/61/106 (2006), 1249 U.N.T.S. 13 (*entered into force* May 3, 2008); Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, (62nd Sess.), paras. 9, 12, U.N. Doc. E/CN.4/2005/51 (2005).

[95] *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 69.

[96] *See* Center for Reproductive Rights, *Bringing Rights to Bear: Abortion and Human Rights* (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/BRB_abortion_hr_revised_3.09_WEB.PDF.

[97] *See, e.g.*, K.L. v. Peru, Communication No. 1153/2003, Human Rights Committee, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); *see also* Tysiąc v. Poland, App. No. 5410/03, Eur. Ct. H.R., para. 116 (2007) ("Once the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it.").

[98] Petition, S. & T. v. Poland, Eur. Ct. H.R. (filed May 19, 2009) (on file with the Center).

[99] CAT Committee, *Peru*, *supra* note 5, para. 23.

[100] *Id.*

[101] *Id.*

[102] CAT Committee, *Nicaragua*, *supra* note 5, para. 16; *El Salvador*, *supra* note 5, para. 23.

[103] CAT Committee, *Nicaragua*, *supra* note 5, para. 16.

[104] CAT Committee, *El Salvador*, *supra* note 5, para. 23.

[105] In Harm's Way, *supra* note 67.

[106] After *In Harm's Way* was written Kenya approved a new Constitution which clarifies the confusing patchwork of 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* Constitution, Art. 26(4) (2010) (Kenya).

[107] Forsaken Lives, *supra* note 67.

[108] CAT Committee, *Chile*, *supra* note 5, para. 7(m).

[109] *Id.*

[110] CAT Committee, *Nicaragua*, *supra* note 5, para. 16.

[111] Manfred Nowak, *Promotion and Protection of all Human Rights, Civil, Political, Economic, Social, and Cultural Rights, Including the Right to Development, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman, and Degrading Treatment and Punishment*, (7th Sess.), para. 72, U.N. Doc. A/HRC/10/44 (2009).

[112] *Id.* para. 71.

[113] Gita Bai came from a rural and low-income background, a family of laborers surviving on a daily wage of INR 25 a day (approximately USD 0.59). *See* Human Rights Law Network, *Report submitted to the magisterial inquiry committee of the death of HIV positive person at MY Hospital in Indore* (Apr. 7, 2007) (on file with the Center).

[114] Center for Reproductive Rights, Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change 18 (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_br_maternal_mortality_in_india_2009.pdf.

[115] CAT Committee, *Concluding Observations: United States of America*, para. 33, U.N. Doc. CAT/C/USA/CO/2 (2006).

[116] *Id.*

[117] Human Rights Committee, *Concluding Observations: United States of America*, para. 33, U.N. Doc. CCPR/C/USA/CO/3/Rev.1 (2006).

[118] *Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 41.

[119] Radhika Coomaraswamy, *Report of the mission to the United States of America on the issue of violence against women in state and federal prisons*, (55th Sess.), paras. 53-54, U.N. Doc. E/CN.4/1999/68/Add.2 (1999).

[120] Aydin v. Turkey, App. No. 57/1996/676/866, Eur. Ct. H.R., paras. 83, 86 (1997).

[121] *Id.*

[122] CEDAW Committee, *General Recommendation 19*, *supra* note 24, paras. 6-7.

[123] *See, e.g.*, CEDAW Committee, *Concluding Observations: Cape Verde*, paras. 19-20, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); *Mali*, paras. 19-20, U.N. Doc. CEDAW/C/MLI/CO/5 (2006); *Mexico*, para. 14, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Thailand*, para. 243, U.N. Doc. A/54/38 (1999); *Togo*, para. 19, U.N. Doc. CEDAW/C/TGO/CO/5 (2006); *United Republic of Tanzania*, para. 213, U.N. Doc. A/53/38/REV.1, Supp. No. 38 (1998).

[124] *See, e.g.*, CEDAW Committee, *Concluding Observations: Fiji*, para. 57, U.N. Doc. A/57/38 (Part I) (2002).

[125] Committee on the Rights of the Child, *General Comment No. 3: HIV/AIDS and the rights of the child*, para. 37, U.N. Doc. CRC/GC/2003/3 (2003).

[126] Paola del Rosario Guzmán Albarracín and next of kin v. Ecuador, Case 1055-06, Inter-Am. C.H.R., Report No. 76/08, OEA/Ser.L/V/II.130 Doc. 22, rev. 1 (2008) (admissibility decision) [hereinafter Paola Guzmán v. Ecuador, Admissibility Decision].

[127] Petition, Paola del Rosario Guzmán Albarracín and next of kin v. Ecuador, Case 1055-06, Inter-Am. C.H.R., (filed Oct. 13, 2006).

[128] Paola Guzmán v. Ecuador, Admissibility Decision, *supra* note 126, para. 41 ("The Commission notes that more than five years have passed since the events in this case occurred, and yet the proceedings have still not produced a definitive resolution of the matter. The petitioners allege that the criminal case has been at a standstill since August 25, 2004, therefore, more than four years, due to the absence of the accused. The Commission observes that the State's only response is to argue that the internal remedies have not been exhausted; however, it provides no information on any measures currently underway or any indication of the other procedural options that the petitioners have available to them.").

[129] *See Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 50 (The procedure often induces girls to enter a state of shock due to the extreme pain, psychological trauma, and exhaustion, and can result in "death through severe bleeding leading to hemorrhagic shock, neurogenic shock as a result of pain and trauma, and overwhelming infection and septicaemia." Psychological consequences of FGM may include "increased likelihood of fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss….").

[130] *Id.* para. 51 (For example, "women may experience long-term consequences such as chronic infections, tumors, abscesses, cysts, infertility, excessive growth of scar tissue, increased risk of HIV/AIDS infection, hepatitis and other blood-borne diseases, damage to the urethra resulting in urinary incontinence, painful menstruation, painful sexual intercourse and other sexual dysfunctions.").

[131] HRC, *General Comment 28*, *supra* note 5, para. 11.

[132] Office of the High Commissioner for Refugees (UNHCR), *Memorandum on Female Genital Mutilation*, para. 7 (May 10, 1994), *cited in Special Rapporteur on Torture—Promotion and Protection of All Human Rights 2008*, *supra* note 5, para. 55 [hereinafter UNHCR, Memo on FGM].

[133] *See, e.g.*, CAT Committee, *Concluding Observations: Indonesia*, para. 16, U.N. Doc. CAT/C/IDN/CO/2 (2008) [hereinafter CAT Committee, *Indonesia*]; *Kenya*, para.

27, U.N. Doc. CAT/C/KEN/CO/1 (2008)[hereinafter CAT Committee, *Kenya*].

[134] CAT Committee, *Concluding Observations: Chad*, para. 30, U.N. Doc. CAT/C/TCD/CO/1 (2009).

[135] *See, e.g.*, CAT Committee, *Concluding Observations: Italy*, para. 4(b), U.N. Doc. CAT/C/ITA/CO/4 (2007); *Togo*, para. 7, U.N. Doc. CAT/C/TGO/CO/1 (2006) [hereinafter CAT Committee, *Togo*]; *Chad*, *supra* note 135, para. 30.

[136] *See, e.g.*, CAT Committee, *Concluding Observations: Cameroon*, para. 7(b), U.N. Doc. CAT/C/CR/31/6 (2003) [hereinafter CAT Committee, *Cameroon*].

[137] *See id.* para. 11(c); *see also* CAT Committee, *Concluding Observations: Australia*, para. 33, U.N. Doc. CAT/C/AUS/CO/3 (2008) [hereinafter CAT Committee, *Australia*].

[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. 33.

[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 2008*, *supra* note 5, para. 53.

[143] *Id.*

[144] *See* UNHCR, Memo on FGM, *supra* note 132, para. 7.

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