



Written comments

Draft update of the General Recommendation No. 19 (1992): accelerating elimination of gender based violence against women

Ipas welcomes the opportunity to submit comments on the Draft Update on the General Recommendation No. 19 (1992): accelerating elimination of gender-based violence against women. Ipas especially welcomes the recommendation 15.j.i that call on Governments to repeal legislation that criminalises abortion. Given that 21.6 million women experience unsafe abortion worldwide and 47,000 women die from complications of unsafe abortion every year¹, reforming unjust criminal abortion laws to expand access to safe care is paramount to advancing women's and girls' health and human rights. We urge the Committee to also explicitly name institutional violence during emergency obstetric care such as abortion care as violence against women and to call attention to the harms of barriers to safe and legal abortion care, which gravely endanger women's health and lives.

The UN Declaration on the Elimination of Violence against Women states in Article 2 that violence against women includes "physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs." Women may suffer physical and psychological harm as a result of structurally inadequate conditions and/or discrimination in institutions and public systems; when governments tolerate such conditions, they are in effect condoning violence against women.

In the field of abortion access and rights, institutional violence exists across a spectrum and has been increasingly receiving international attention from human rights treaty monitoring bodies. Women who seek abortion care frequently face institutional violence within the health-care and legal systems, including inhumane and degrading treatment such as withholding medical care and pain management medications, accusations and forced confessions, threats, humiliation and insults. In more than one case documented by Ipas in Latin American countries, women were shackled and arrested while they were still in the hospital bed convalescing from haemorrhage caused by the abortion process.

Punitive attitudes on the part of health providers may also lead to delays in care. When treatment for the complications of incomplete abortions is delayed, women may face grave harm to their health, including serious infections, sterility and even death. Judges and health-care providers may also cause excessive delays in granting permission for and carrying out legal abortions.

Ipas has been working with partners to eliminate barriers in health policies and practices that violate women's human rights, including systematic provider refusal to provide abortion care to victims of sexual violence victims. Ipas work in different countries focus on the need eliminate barriers and promote policy change in order to ensure women's right to sexual autonomy and informed choices, and

¹ http://www.who.int/reproductivehealth/topics/unsafe_abortion/magnitude/en/

to ensure women and girls have access to comprehensive sexual and reproductive health services as part of their right to live free from violence.

In the last several decades, UN treaty-monitoring bodies have reiterated that denying survivors of sexual violence access to safe abortion constitutes a violation of the woman's human right, including constituting cruel, inhumane and degrading treatment.¹ Also, in the past decade, domestic, familial and intimate partner violence have also been recognized as violations of human rights. Some countries have adopted comprehensive policies to combat violence against women, whereas others have been slow to address the problem and effectively address the root causes associated with violence, particularly sexual violence, including the patriarchal need to control women's bodies or otherwise prevent women from exercising autonomous decision-making, seeking independence and living free from coercion, stigma and discrimination.

States have a duty to provide for the safety and public health of their people through establishment of laws and policies and such grounds and can never justify denying to women and adolescents the protection of their basic human rights.

Delays in care, lack of information and privacy, discomfort... cruel and inhuman care: institutional violence

Between 2008 and 2010, Ipas and Grupo Curumim, in partnership with women's organizations, carried out a study on women's access to legal abortion in capital cities and large municipalities of the states of Bahia (Salvador and Feira de Santana), Mato Grosso do Sul (Campo Grande and Corumbá), Paraíba (João Pessoa and Campina Grande), Pernambuco (Recife and Petrolina) and Rio de Janeiro (Rio de Janeiro, Duque de Caxias and Nova Iguaçu).²

Interviews with women and providers in the five states showed that health facilities lack infrastructure to provide timely care, women are subjected to discriminatory waiting periods, the quality of care is poor, and they suffer discrimination and judgmental attitudes from health-care providers based on moral and religious beliefs.

Lack of infrastructure

The study team found that women residents of small or medium-sized municipalities often are transferred to maternity hospitals in capital cities for abortion-related care, because local hospitals do not have appropriate care conditions, or because health professionals boycott abortion care.

² Soares GS, Galli MB, de A.L. Viana AP. March 2011. *Advocacy for access to safe legal abortion: similarities in the impact of abortion's illegality on women's health and health care in Pernambuco, Bahia, Mato Grosso do Sul, Paraíba and Rio de Janeiro*. Chapel Hill, NC, Ipas. <http://www.ipas.org/~media/Files/Ipas%20Publications/5statesENG.ashx>

For example, nearly 30 and 28% of obstetric hospitalizations for treatment of abortion complications in the municipal networks of Recife and Feira de Santana, respectively, were for women who reside outside the municipalities. In João Pessoa and Campina Grande, the percentage of non-residents who received care were even higher— 44% in the former and 52% in the latter. In Mato Grosso do Sul state, a geographic location on the border with Bolivia and Paraguay and a high number of indigenous people treated by the public health system are factors that contribute to women’s vulnerability to morbidity due to unsafe abortion.

Long waiting periods

Priority care was given to pregnant women in labour at all the facilities studied, resulting in longer hospital stays for the women receiving abortion care. There is an informal policy that prioritizes care for pregnant women who are in labour. That standard was found in all the facilities researched, which clearly lengthens clients’ hospital stays. When they presented at the maternity hospital, women reported waiting two or three hours in the reception or triage area, even when they were in pain or haemorrhaging. As one woman in Bahía stated:

“We arrived early; I remember that there were only two people ahead of me, but they were taking a long time to treat me. Other people started arriving and they went right in front of me; I think it’s because they knew that I had induced an abortion. I think that when women induce an abortion, they punish them harshly, leaving her lying in a corner. I was with my sister and my mother; we waited in the waiting area, but they did not take me in; they didn’t even bring a bed; I remained seated. I had a very big tampon, but even so, when I got up from the chair, I saw that my clothes were drenched in blood. The receptionist called the doctors. I think that if they had not seen all that blood, it would have taken longer. I know that I got there at 7 a.m. and they took me in around 10:00.”

Another woman in Rio de Janeiro said:

“I was not treated badly here, but that room is very cold and the conditions are horrible. If I had not brought a bedspread from home, I would be freezing in that uncomfortable chair. I’ve been here since yesterday, 24 hours thus far, 12 hours and 45 minutes without eating; I think that I’m waiting for a curettage procedure, which I believe will be performed this afternoon, but here no one informs you of anything...”

A health professional in Petrolina explained: *“Sometimes even with haemorrhage...there was a case of a woman who smelled awful when she was finally able to be seen; she spent more than a day waiting in triage, with missed abortion, with sepsis, even so, she was the last one to be seen that day. That’s how it is; when it’s an abortion, they don’t even want to know whether it was spontaneous or induced; the woman is left for last in admissions.”*

Poor quality of care

Patients awaiting treatment are usually subjected to fasting. When women must wait for long periods for post-abortion care, hunger is a problem. A young woman in João Pessoa said:

“It took a long time to perform that sharp curettage. It took my boyfriend’s aunt arguing and saying something...Then it was my mom who went to talk to them. They told her: ‘stay calm, you have to stay calm’. She said: ‘how can I stay calm when my daughter has already been fasting for four days. What kind of fast is that? Is it Holy Week fasting? Is my daughter going to die by chance?’ Then, they

answered: 'in three hours'. Three hours turned into after the visit. Six hours had gone by when they finally performed it, and that was because my mother went to complain again."

Discrimination is also related to lack of space in overcrowded maternity hospitals; as a health professional in Rio de Janeiro commented: *"If there are three good rooms and a bad one, the woman who presents with abortion complications will be put in the worst room."*

In Salvador and Campo Grande, there were reports of sharp curettage procedures performed without anesthesia, a very common practice which has been denounced for years. A health professional in Petrolina stated:

"They do not agree to anesthetize the women to perform the sharp curettage procedures at night; they leave everything for the morning shift. They don't get up. If another woman comes in for a sharp curettage, she could be bleeding, haemorrhaging, and they would say a joke like: 'gather all the curettage clients and they'll be next'."

At one maternity hospital in Campina Grande, women were discharged from the hospital immediately after the sharp curettage, which is considered evidence of carelessness and negligence, especially in contexts of poverty when women need to return to work immediately after leaving the hospital, and sometimes have neither a companion nor transportation to return home.

Lack of privacy and violations of women's rights to dignity and bodily integrity were also reported by women interviewed in Mato Grosso do Sul and Bahia:

"You are thrown into a corner and they give you bad looks. So as not to say that they did not pay any attention to me, that happened a day after, when a group of academicians was 'invited' by a physician to see my situation. There were about six of them, and they all touched me to feel something the physician was showing them. Today, I can't believe that I allowed them to do that to me! They would simply come in, insert their hand, and they did not even say a word to me. It's as if I were a thing, an object. "

"I was in the waiting area waiting to undergo sharp curettage; they threw you in there as if it were some kind of punishment. I thought I was being punished. And I was there the whole day, Mother's Day.... The doctor came, examined me, and said nothing, absolutely nothing. I remained there in the hospital gown. And then the interns came, lifted the gown and inserted their fingers, without saying a word. One right after the other would approach me, and I felt awful..."

Due to the clandestine nature of many abortions and knowledge about institutional violence, women were found either not to seek abortion care or to do so late. When they presented at a facility, they often said they were spontaneously bleeding, without mentioning having induced an abortion, as a strategy to protect themselves against providers' judgments and discrimination, as well as against the growing threat of being reported or imprisoned.

The team found that providers' attitudes are characterized by religious moral values, which make it difficult for them to treat abortion cases. Many health-care providers are Catholic or Evangelical and explain their unwillingness to provide care as the result of their wish to defend life. Providers were seen to judge women, adopt punitive and discriminatory attitudes, or refuse to perform legal abortion procedures.

Conclusion

The situations described above by women in their testimonies indicate their powerless state within health-care facilities when they sought abortion care. The Committee against Torture (CAT Committee) has confirmed that women are vulnerable to torture or ill-treatment in the context of: “.. *medical treatment, particularly involving reproductive decisions,.. and that they may be subject to violations of the CAT on the basis of their “actual or perceived non-conformity with social determined gender roles.”*”³

The CESCR Committee, in its General Comment 14, paragraph 8, stated that: “*The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.*”⁴

Sexual and reproductive health and rights (SRHR) imply that individuals should have control over their bodies and, in turn, live their lives, be healthy and have sexual and reproductive autonomy. Survivors of sexual violence often experience high levels of stigma and discrimination, which may deter them from accessing health services, including emergency contraception, safe abortion, counselling and other essential services, for fear of family or community members becoming aware of their experience.

The root cause of both violence and restrictions on women’s exercise of their sexual and reproductive rights is the same: systematic gender discrimination and, relatedly, control over women’s sexuality and decision-making. Across the world, violations of these aspects of women’s fundamental human rights go hand in hand, and mark the starkest forms of control and limitation on women’s freedoms and equality. Various forms of gender-based violence are themselves specific violations of sexual and reproductive rights, among them all forms of sexual violence, including marital rape, and any coercive policy or practice that intervenes in women’s informed, autonomous decision-making about their own bodies, sexuality or reproductive choices.

We hope that this information will be helpful. Please do not hesitate to contact [Beatriz Galli](mailto:Beatriz.Galli@gallib@ipas.org) gallib@ipas.org if you have any questions or concerns about any of the information contained herein.

³ Committee against Torture (CAT Committee) General Comment 2, Implementation of article 2 by states parties, par. 15. U.N. Doc CAT/C/GC?2 (2008).

⁴ Committee on Economic Social and Cultural Rights. General Comment No. 14 (2000). The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) E/C.12/2000/4 11 August 2000.