

May 17, 2019

Special Rapporteur on Violence Against Women

OHCHR-UNOG,

8-14 Avenue de la Paix

1211 Geneva 10, ​ Switzerland

**Response to call for submissions: Mistreatment and violence against women during reproductive health care with a focus on childbirth**

Ipas welcomes the opportunity to submit comments to inform the Special Rapporteur on violence against women’s next thematic report on mistreatment and violence against women during reproductive health care. Ipas, established in 1973, is an international non-governmental organization based in the United States. Ipas currently supports 19 regional or country offices and maintains a presence in more than 20 others in Africa, Asia, and Latin America. Working with local partners around the world, we strive to improve women’s access and right to safe, high-quality abortion care and contraception. Ipas trains providers in abortion care, works to strengthen health systems, and advocates around the world for safe, legal abortion.

Given that 21.6 million women experience unsafe abortion worldwide and 47,000 women die from complications of unsafe abortion every year[[1]](#footnote-1), reforming unjust criminal abortion laws is paramount to advancing women’s and girls’ health and human rights and ensuring their safety when accessing reproductive health services. We applaud the explicit naming of institutional violence during reproductive health care such as abortion care as violence against women and hope to call attention to the harms of barriers to safe and legal abortion care, which gravely endanger women’s health and lives and lead to mistreatment in reproductive health settings.

**International human rights standards on abortion**

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. [[2]](#footnote-2)

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. The Committee on the Elimination of All forms of Discrimination of Women has explicitly named criminalization of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, as forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment,[[3]](#footnote-3) and urged states to repeal criminal abortion laws[[4]](#footnote-4).

The Committee against Torture (CAT) 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 socially-determined gender roles.’”[[5]](#footnote-5) CAT has regularly found that the denial of access to post-abortion care may constitute torture or ill-treatment. This Committee noted particular concern in one case in which health providers coerced women who sought life-saving treatment after illegal abortions to provide information on who provided the abortion.[[6]](#footnote-6) In that case, the Committee urged the state to eliminate the practice of extracting confessions for purposes of prosecution from women seeking emergency medical care as a result of illegal abortion and called for remedial measures, including nullifying convictions not found to be in conformity with the Convention.[[7]](#footnote-7) The Committee has also urged that States must ensure immediate and unconditional treatment for persons seeking emergency care, in compliance with World Health Organization guidelines.[[8]](#footnote-8)

CAT has found that complete bans on abortion may constitute torture or ill-treatment on their face, as they place women at risk of preventable maternal mortality. In its 2009 review of El Salvador, the Committee recommended that the State party take measures to prevent torture and ill-treatment 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.[[9]](#footnote-9) The Committee has also expressed concern over laws criminalizing abortion in cases of rape, incest, or when the fetus is not viable—noting that such laws mean that women “are constantly reminded of the violation committed against them, which causes serious traumatic stress and carries a risk of long-lasting psychological problems.”[[10]](#footnote-10) This Committee has also noted with concern the existence of abuses against women in reproductive health facilities, finding that they may also constitute torture or ill-treatment. In its 2013 review of Kenya, the CAT expressed concern about “the on-going practice of post-delivery detention of women unable to pay their medical bills, including in private health facilities,” and urged the State party to strengthen efforts to end these practices as a means to preventing torture or ill-treatment.[[11]](#footnote-11)

As the authority on the right to health, Committee on Economic, Social and Cultural Rights (CESCR) has elaborated on this right in its **General Comment 14**, specifying that states must implement measures to “(i)mprove child and maternal health, sexual and reproductive health care services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as resources necessary to act on that information.”[[12]](#footnote-12) Furthermore, in its most recent **General Comment 22** on the right to sexual and reproductive health under article 12, CESCR stated that the “right to sexual and reproductive health is an integral part of the right to health enshrined in article 12” and full enjoyment of this right is often limited by a number of legal, procedural, practical, and social barriers.[[13]](#footnote-13) Specific to abortion restrictions, the General Comment notes that denial of abortion services often contributes to increased maternal mortality and morbidity, constituting a violation of the right to life or security, and sometimes amounting to torture or cruel, inhuman or degrading treatment.[[14]](#footnote-14) The CESCR General Comment 22 also calls for the repeal or reform of discriminatory laws, policies and practices in the area of sexual and reproductive health, *including liberalization of restrictive abortion laws*, as well as the removal of all barriers that interfere with access by women to comprehensive sexual and reproductive health services, goods, education and information.[[15]](#footnote-15)

**Abortion inside and outside the health system**

Even where abortion is legal under broad circumstances, mistreatment within the health system and legal barriers mean poor, uneducated, young, and otherwise marginalized groups turn outside the health system to end their pregnancies. Many abortion laws include provisions regulating who can provide abortion and where and require women seeking abortion to report to law enforcement authorities in cases of rape, seek parental involvement, be subject to compulsory biased counselling or waiting periods, or overcome other barriers.[[16]](#footnote-16) Either because women are unable to meet these requirements, or because they anticipate mistreatment within the health system, women are increasingly turning outside the formal health care system for abortion with pills.

Abortion with pills is safe and evidence is growing that women can safely use misoprostol with mifepristone or misoprostol alone to end a pregnancy without the involvement of a healthcare professional.[[17]](#footnote-17) This development is so ground-breaking that the abortion research field has reconceived the notion of abortion safety.[[18]](#footnote-18) Researchers have attributed abortion with pills outside formal health care settings to a worldwide decrease in abortion mortality.[[19]](#footnote-19) Even in the most liberal legal environments, women are pushed to seek illegal abortion because of the dearth of health professionals willing and able to provide abortion and the overall global shortages of health care workers, or choose to seek abortion outside the health sector because of concerns about privacy or stigma. Many of these abortions, which are illegal only because of the lack of involvement from the formal health care system, are safe but nevertheless remain criminalized.

Self-induced abortion outside the formal health care setting is criminalized throughout the world. An analysis of 196 countries’ laws using the World Health Organization’s (WHO) Global Abortion Policies Database reveals that all but Canada and China criminalize abortion outside the formal health-care system.[[20]](#footnote-20) Through criminal law, lawmakers impose penalties of imprisonment upon individuals who provide abortion without required education, training, certificate, or license. In nearly every country in the world, women who procure abortions on their own and the individuals that help them face risk of criminal penalties. Nearly all the 40 laws that have changed since the 1994 International Conference on Population and Development require that a specified healthcare professional be involved in the abortion decision.

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[[21]](#footnote-21).

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. Ipas’s work in different countries focuses on the need eliminate barriers and promote policy change in order to ensure women’s right to sexual autonomy and informed choices, and to ensure women and girls have access to comprehensive sexual and reproductive health services as part of their right to live free from violence.

**Research: Bolivia, Argentina, Brazil**

Ipas investigated the enforcement of laws criminalizing abortion in three South American countries—Bolivia, Brazil and Argentina. In Bolivia, Brazil and Argentina, abortion is highly restricted. In the rare circumstances under which abortion is legal, the legal barriers to access are insurmountably high. These barriers include requirements that a medical professional provide the abortion, judicial authorization, and burdensome waiting periods, among others. Ipas documented accounts of hundreds of women and health-care providers who violated abortion-related laws and were arrested, charged, detained and imprisoned[[22]](#footnote-22).

In **Bolivia**, police investigations were initiated in 775 abortion cases from 2008–2012, although relatively few led to convictions. Under Bolivian law at the time, women who are pregnant as the result of rape must begin criminal proceedings against the perpetrator before they can request judicial authorization for an abortion. But judges rarely authorized abortions, generally claiming conscientious objection based on religious and moral grounds. In one troubling case, a 28-year-old woman in the city of Santa Cruz become pregnant as the result of rape. She attempted to self-induce an abortion and ended up in the hospital with severe complications. While in the hospital, she was reported to the police authorities by her doctor, was apprehended and handcuffed on charges of illegal abortion. She spent her 10-day hospital stay under police custody and was then transferred to a prison where she spent eight months in detention for illegal abortion.

In **Argentina**, Ipas and its partners identified 417 cases where individuals received sentences for the crime of abortion during the period from 1990 to 2008, the majority against women seeking abortions and unskilled individuals who were providing services. In one case, a female physician and mother of two, reported to law enforcement authorities and spent more than a year under the threat of criminal action for prescribing misoprostol, a medication recommended by the World Health Organization for the termination of pregnancy. Finally, the case was closed, but the physician had to suffer the stigma and uncertainty of an open criminal action against her for more than a year.

In **Brazil**, health care professionals and people in need of abortion face increasing criminalization. With Brazilian partners Ipas carried out a study in Rio de Janeiro state which found between 2007– 2011 there were 334 police reports involving women who had had illegal abortions. Court records from 2007– 2010 show that 128 women were prosecuted. In one case a woman was arrested in the hospital after seeking post abortion care. She was unable to afford bail and for three months remained handcuffed to her hospital bed.

In Brazil the Ministry of Health has considered misoprostol an essential medicine since 2010. However, the National Regulatory Agency on Health policies (ANVISA) prohibits information about abortion with misoprostol and bans the drug in pharmacies. People seeking misoprostol for abortion turn to informal markets and face potential counterfeit medicines, high cost, and lack of information on how to use the drug properly, at great risk to their reproductive health and lives. Women seeking abortion with pills often receive inaccurate information on dosage from drug sellers. When they seek post-abortion care in public health facilities they risk being reported to the police. Women of lower socio-economic status are more likely to be prosecuted for abortion in Brazil and face high penalties. The Anis Institute and the University of Brasilia analyzed police investigations and criminal cases against women and misoprostol sellers and found that most women who were prosecuted for abortion were domestic workers and traders have a low literacy rate.[[23]](#footnote-23) Additional research found that in criminal cases in which misoprostol is purchased and sold illegally, judges have applied high penalties.[[24]](#footnote-24)

**Additional Research: Brazil**

*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 in Brazil on women’s access to legal abortion in capital cities and large municipalities of the states of Bahía (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).[[25]](#footnote-25)

**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**[[26]](#footnote-26)**.**

*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.

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[[27]](#footnote-27).

*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.”[[28]](#footnote-28)*

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... “[[29]](#footnote-29)*

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.[[30]](#footnote-30)”*

*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. Abortion is a common health care service that women need and does not belong in the criminal law. Global authorities must recommend total decriminalization of abortion, not only for women who self-induce abortion, but for everyone who needs one. To ensure women’s rights to health, nondiscrimination, and freedom from violence, abortion must be removed from the criminal law, everywhere.

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 and any coercive policy or practice that intervenes in women’s informed, autonomous decision‐making about their own bodies, sexuality and criminalizes their reproductive choices.

We hope this information has been helpful. Please contact Elizabeth Guthrie at elizguthrie@ipas.org with any requests for additional information, other questions, or concerns.

1. <http://www.who.int/reproductivehealth/topics/unsafe_abortion/magnitude/en/> [↑](#footnote-ref-1)
2. UN Declaration on the Elimination of Violence against Women, Article Two (20 December 1993). A/RES/48/104. [↑](#footnote-ref-2)
3. CEDAW General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19 (2017), par. 18. [↑](#footnote-ref-3)
4. Ibid*,* par. 31a. [↑](#footnote-ref-4)
5. Committee against Torture (CAT Committee) General Comment 2, Implementation of article 2 by states parties, par. 15. U.N. Doc CAT/C/GC2 (2008). [↑](#footnote-ref-5)
6. *See* CAT Committee, *Concluding Observations*, **Chile,** par. 4(h),U.N. Doc. CAT/CR/32/5 (2004). [↑](#footnote-ref-6)
7. *Ibid.* at par. 7(m). [↑](#footnote-ref-7)
8. *Ibid.* [↑](#footnote-ref-8)
9. CAT, *Concluding Observations,* **El Salvador**, par. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009). [↑](#footnote-ref-9)
10. CAT, *Concluding Observations,* **Paraguay**, par. 23, U.N. Doc. CAT/C/PRY/CO/4-6 (2011). *See also*, CAT, *Concluding Observations,* **Nicaragua**, par. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009) (noting that denial of access to abortion in cases of sexual violence can cause serious traumatic stress and risk of long-lasting psychological problems such as anxiety and depression, recommending that abortion be legal in cases of sexual violence). [↑](#footnote-ref-10)
11. CAT, *Concluding Observations*, **Kenya**, par. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013). [↑](#footnote-ref-11)
12. Committee on Economic, Social and Cultural Rights (CESCR), *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)* (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 90, par. 14, U.N. Doc. HRI/GEN/1/Rev.5 (2001). [↑](#footnote-ref-12)
13. CESCR, *General Comment 22: The Right to Sexual and Reproductive Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* pars. 1-2 (May, 2016). [↑](#footnote-ref-13)
14. *Ibid.* at par. 12. [↑](#footnote-ref-14)
15. *Ibid.* at par. 28. [↑](#footnote-ref-15)
16. World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems, WHO, 2012. [↑](#footnote-ref-16)
17. Jelinska, K, and Yanow, S. Putting abortion pills into women's hands: realizing the full potential of medical abortion. Contraception, 2018, 97(2):86-89. [↑](#footnote-ref-17)
18. Ganatra, B, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, Lancet, 2017, 390(101110):2372-2381. [↑](#footnote-ref-18)
19. *Ibid*. [↑](#footnote-ref-19)
20. Skuster P, Jelinska J and Yanow S, Self-managed abortion highlights need to decriminalize abortion worldwide, Rewire, 2018. [↑](#footnote-ref-20)
21. Kane, G, Galli, B, & Skuster, P. When abortion is a crime: The threat to vulnerable women in Latin America (third ed.), Ipas, 2013. [↑](#footnote-ref-21)
22. *Ibid*. [↑](#footnote-ref-22)
23. Diniz, D & Madeiro, A. Cytotec and abortion: the police, the vendors and women, Ciênc. saúde coletiva, 2012, 17(7): 1795-1804. [↑](#footnote-ref-23)
24. (7): 1795-1804. 20 Women on Web, Testimony for the Supreme Court in Brazil (2017), available at https://www.womenonweb.org/en/page/16662/women-on-web-testimony-for-the-supreme-court-in-brasil. [↑](#footnote-ref-24)
25. 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, Bahía, Mato Grosso do Sul, Paraíba and Rio de Janeiro.* Chapel Hill, NC, Ipas. [↑](#footnote-ref-25)
26. *Ibid*. [↑](#footnote-ref-26)
27. 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, Bahía, Mato Grosso do Sul, Paraíba and Rio de Janeiro.* Chapel Hill, NC, Ipas. [↑](#footnote-ref-27)
28. *Ibid*. [↑](#footnote-ref-28)
29. *Ibid*. [↑](#footnote-ref-29)
30. *Ibid*. [↑](#footnote-ref-30)