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Ms Hannah Wu  
Secretary  
Working Group on the issue of discrimination  
against women in law and in practice  
Office of the High Commissioner for Human  
Rights (OHCHR) - UNOG  
CH-1211 Geneva 10  
Switzerland

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**AMNESTY  
INTERNATIONAL**



AMNESTY INTERNATIONAL INTERNATIONAL SECRETARIAT  
Peter Benenson House, 1 Easton Street  
London WC1X 0DW, United Kingdom  
T: +44 (0)20 7413 5500 F: +44 (0)20 7956 1157  
E: [amnestyis@amnesty.org](mailto:amnestyis@amnesty.org) W: [www.amnesty.org](http://www.amnesty.org)

**INFORMAL SUBMISSION: POSSIBLE TOPICS FOR A REPORT ON WOMEN'S HEALTH AND SAFETY**

Dear Ms Wu,

Following our conversation in April 2015 concerning the Working Group on the issue of discrimination against women in law and in practice (the Working Group)'s next thematic report on women's health and safety, Amnesty International is pleased to submit the attached informal briefing for the attention of the members of the Working Group. The briefing should be considered as initial suggestions of issues that could be addressed in the 2016 report to the Human Rights Council.

The briefing raises issues concerning criminalization of sexual and reproductive actions and decisions, including adolescent sexuality, the provision of sexual and reproductive health services, sex work and conduct during pregnancy. It also includes information on conscientious objection to abortion, access to post-rape health care information, services and goods, transgender people's access to sexual and reproductive health care and information, and the impact of intersectional discrimination on women's and girls' health and safety.

We hope that the issues raised are useful for your initial discussions and look forward to contributing to the consultation process.

Yours sincerely,

Anna-Karin Holmlund  
International Advocacy Program

# INFORMAL SUBMISSION: POSSIBLE TOPICS FOR A REPORT ON WOMEN'S HEALTH AND SAFETY

## 1. INTRODUCTION

Women and girls' health and safety are interconnected and interdependent. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."<sup>1</sup> Without guaranteeing safety,<sup>2</sup> it is impossible to ensure women's and girls' social well-being and further, their human right to health, including sexual and reproductive health, and other related rights such as their rights to bodily integrity, to privacy and to be free from violence, discrimination and torture or cruel, inhuman or degrading treatment.

Sexual and reproductive health is a central component of health, and crucial for the realization of women's and girls' autonomy, sexual and reproductive rights and their full range of human rights. The lack of safety due to armed conflict or natural disaster may have a gender-specific, negative impact on women's and girls' health, including their sexual and reproductive health. Women and girls may be cut off from access to the vital health services and information they need, face multiple barriers to accessing such services or experience the negative health consequences of gender-based and sexual violence without access to medical care and other support services.

Even in peace time, pervasive gender-based discrimination resulting in women and girls being targeted for sexual violence, punished or criminalized for their sexual and reproductive actions and decisions, or denied access to vital health services and information needed only by them, has also negatively impacted women and girls' health and safety. Moreover, women and girls may face discrimination, coercion or violence, and their safety may be put at risk, when seeking sexual and reproductive health services and information, or otherwise claiming their sexual and reproductive rights.

The Programme of Action (PoA) adopted at the International Conference on Population and Development (ICPD) in 1994 in Cairo, recognized the importance of sexual and reproductive health for the realization of all women's rights and empowerment, gender equality, and for achieving sustainable development and building peaceful societies. In the years since the ICPD PoA was adopted, some important steps have been taken to realize the commitments it set out. Nevertheless, the twenty-year review of its implementation showed that progress in relation to ensuring universal access to sexual and reproductive health has been uneven and mixed. For example, while improvements in reproductive health services, such as antenatal care, have been reported, in other areas, notably safe abortion and comprehensive sexuality education, progress has been woefully inadequate.<sup>3</sup>

Sexual and reproductive health services specifically needed by women and girls are often not available because they are not seen as a priority by governments. Additionally, women's and girls' autonomy to make decisions over their sexuality and reproduction is often denied through criminalization of sexual and reproductive health services, introduction of legal and policy barriers, and/or failures to challenge

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<sup>1</sup> Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

<sup>2</sup> At this point, it is unclear how the Working Group will define "safety." For purposes of this submission, Amnesty International will use the term as it relates to women's and girls' physical and emotional safety and wellbeing, as well as their bodily autonomy and integrity.

<sup>3</sup> See Gita Sen, Status of the ICPD Agenda: the Present, Fifth International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action, Istanbul, May 2012.

religious, cultural or traditional attitudes or practices, which impede women's and girls' autonomous decision-making with regard to their bodies and reproductive capacities.<sup>4</sup>

Even where governments have developed programmes and allocated resources to sexual and reproductive health, the impact has often been limited because they have not addressed the structural barriers that prevent women and girls from obtaining access to these services. Progress on these issues has been marred by deepening inequalities between and within countries, with the most marginalised groups being left behind, due to the continued failure by governments to address underlying discrimination and structural inequalities.

Women and girls most at risk of discrimination and marginalization due to their sex and gender and other factors such as ethnicity, caste, Indigenous, minority or migrant status, age, marital status, disability, gender identity or sexual orientation, or other characteristics of their identity and/or socio-economic status continue to experience denial of their sexual and reproductive rights and face multiple barriers in accessing sexual and reproductive health services and information. Lack of political will often results in states' failure to address these additional barriers. The first step is to ensure that multiple barriers are recognised and understood through the collection and disaggregation of data to inform development of evidence-based programmes and policies.

With these realities in mind, Amnesty International hopes that the Working Group will consider the below-referenced thematic sexual and reproductive health and rights issues when developing its upcoming report on women's health and safety.

## 2. CRIMINALIZATION OF SEXUAL AND REPRODUCTIVE ACTIONS AND DECISIONS

The criminalization of sexual and reproductive actions and decisions acts as a major barrier to the realization of women's and girls' human rights. States worldwide apply criminal and other punitive laws and policies, to police and punish conduct and individuals who do not ascribe to traditional sexual and gender norms. Sometimes this is done by direct regulation through laws and policies that specifically target sexual and reproductive actions and decisions, such as bans on abortion, sex outside marriage or same-sex sexual activity. Other times it is done through indirect regulation using a range of criminal, civil and religious laws and policies, such as public order or morality offences, to police and punish particular sexual and reproductive actions, decisions and/or sexual or gender identities.

States pass and enforce such policies and legislation claiming that the measures protect "morality," increase safety, reduce harm, or encourage health-promoting behaviour. However, these assertions are being challenged around the world, particularly by human rights activists and health professionals. Additionally, there is growing recognition that criminalizing sexuality and reproduction in fact increases the risks to individuals and communities and obstructs the provision of effective health services.<sup>5</sup>

States have a positive obligation under international human rights law to provide a functioning and accountable legal and policy system to ensure safety and public health. But they do not have unlimited power to regulate lives in a manner that violates human rights and infringes upon human dignity.<sup>6</sup>

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<sup>4</sup> For example: The total abortion ban in Nicaragua: Women's lives and health endangered, medical professionals criminalized Amnesty International AMR 43/001/2009; Listen to their voices and act: Stop the rape and sexual abuse of girls in Nicaragua, Amnesty International, AMR 43/008/2010; Left without a choice: Barriers to reproductive health in Indonesia, Amnesty International ASA 21/013/2010; On the brink of death: Violence against women and abortion ban in El Salvador, Amnesty International AMR 29/003/2014.

<sup>5</sup> See Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. Doc. A/HRC/14/20 (2010) [hereinafter 2010 Report of the Special Rapporteur on the Right to Health]; Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. Doc. A/66/254 (2011) [hereinafter 2011 Report of the Special Rapporteur on the Right to Health]; UNDP, Global Commission on HIV and the Law, *Risks, Rights & Health* (2012). [hereinafter *Risks, Rights & Health*]

<sup>6</sup> See Diya Uberoi, Maria de Bruyn and Beatriz Galli, *Using Human Rights to Address Consequences of Criminal Laws on Sexuality and Reproductive Autonomy*, INTERNATIONAL JOURNAL OF HUMAN RIGHTS 11 (2012).

When states criminalize consensual sexual and reproductive actions, decisions and identities, they overstep legitimate limits and breach international human right norms. Set forth below are a few sexual and reproductive rights issues that are criminalized around the world that the Working Group may consider addressing in its upcoming report.

## 2.1 ADOLESCENT SEXUALITY

Adolescent sexuality is often criminalized through “age of consent” laws which set a particular age that adolescents are deemed legally capable of consenting to sex. Enforcement of these laws tends to narrowly hinge on chronological age, as opposed to whether the sexual actions were consensual and without regard to qualitative power relations between the individuals involved.<sup>7</sup>

In addition to leading to unjust punishment in some cases, “age of consent” laws can be discriminatory, providing for a lower “age of consent” for girls and/or a higher “age of consent” for same-sex activity between boys and men.<sup>8</sup> Young women can also be disproportionately punished under these laws due to pressures to curtail their sexual expression and to remain “chaste.” Along those lines, the United Nations (UN) Committee on the Elimination of Women (CEDAW) has expressed concern that “the penalization of consensual sexual relations among young people between 15 and 18 years of age may have a more severe impact on young women, especially in the light of the persistence of patriarchal attitudes.”<sup>9</sup> The consequences of this reality are compounded by the fact that women and girls generally bear the burden of preventing unwanted pregnancies and sexually transmitted infections (STIs).

While states have an obligation under international law to protect adolescents from sexual coercion and violence, they are also required to provide access to sexual and reproductive health information and services in accordance with adolescents’ “evolving capacities.”<sup>10</sup> With regard to sexuality, the principle of “evolving capacities” also requires that adolescents have access to the means to explore and realize their sexual development. To that end, human rights bodies have called upon states to recognize adolescents as rights holders,<sup>11</sup> and (in accordance with the principle of “evolving capacities”), not to impose strict “age of consent” requirements on them.<sup>12</sup>

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<sup>7</sup> Evolving recognition of privacy rights for adults engaging in same-sex sexual conduct are often not equally applied to adolescents. See *Lawrence v. Texas*, 539 U.S. 558 (2003) (While the United States Supreme Court struck down sodomy laws as unconstitutional, it explicitly noted that its decision did not apply to “minors.”).

<sup>8</sup> Notably, in 2011, the UN High Commissioner for Human Rights called for the repeal of discriminatory laws that criminalize people on the grounds of their sexuality and gender, specifically laws that criminalize same-sex sexual activity or enforce higher age of consent thresholds for sex between same-sex partners. See Report of the United Nations Office of the High Commissioner for Human Rights, Discriminatory Laws and Practices and Acts of Violence against Individuals based on their Sexual Orientation and Gender Identity, Human Rights Council, 19th Sess., 17 November 2011, A/HRC/19/41, para. 84(d) (2011) [hereinafter 2011 Annual Report of the OHCHR]; see also Concluding Observations of the Committee on the Rights of the Child: Chile, U.N. Doc. CRC/C/CHL/CO/3, para. 29 (2007); the United Kingdom of Great Britain and Northern Ireland: Isle of Man, U.N. Doc. CRC/C/15/Add.134, para. 22 (2000); Concluding Observations of the Human Rights Committee: Austria, U.N. Doc. CCPR/C/79/Add.103, para. 13 (1998). Amnesty International also calls for states to harmonize “age of consent” in *Making Love a Crime: Criminalization of Same-Sex Conduct in Sub-Saharan Africa*, Amnesty International AFR 01/001/2013, available at [http://www.amnestyusa.org/sites/default/files/making\\_love\\_a\\_crime\\_-\\_africa\\_igbti\\_report\\_emb\\_6.24.13\\_0.pdf](http://www.amnestyusa.org/sites/default/files/making_love_a_crime_-_africa_igbti_report_emb_6.24.13_0.pdf) (last accessed 24 April 2015).

<sup>9</sup> Concluding Observations of the UN Committee on the Elimination of Discrimination against Women: Turkey, U.N. Doc. A/60/38 part I, at paras. 363-64 (2005).

<sup>10</sup> International Convention on the Rights of the Child, U.N. Doc. A/44/49, Articles 5, 14 (1989) [hereinafter CRC]; UN Committee on the Rights of the Child, General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child, U.N. Doc. CRC/GC/2003/4, paras. 7, 16 (2003) [hereinafter CRC, General Comment 4 (Adolescent Health)].

<sup>11</sup> See CRC, supra note 11, at paras. 9, 12.

<sup>12</sup> See *id.* at paras. 9 and 12.

## 2.2 PROVISION OF SEXUAL AND REPRODUCTIVE HEALTH INFORMATION

Many states criminalize the provision of sexual and reproductive health information, an essential component of individuals' enjoyment of their rights to access information and education, and equality and non-discrimination. For example, overbroad application of anti-pornography or "obscenity" laws or other administrative and public health laws or policies can impede individuals' exercise of their sexual and reproductive rights, stifle discourse around sexual and reproductive health, and fuel stigma and discrimination; often with a disproportionate impact on women, young people and those with non-normative sexual orientations and gender identities.

Information-related restrictions can also make it harder for adolescents to protect themselves from STIs and early and unwanted pregnancies, and to exercise informed and autonomous sexual and reproductive health decision-making, in accordance with their "evolving capacities."<sup>13</sup> Moreover, laws criminalizing sexual and reproductive health information pose grave implications for public health. As noted by the UN Special Rapporteur on the Right to Health, public health and empowerment programmes and activities such as educational campaigns on HIV/AIDS and STI prevention, family planning, domestic violence, gender discrimination, female genital mutilation, sexual diversity, overall sexual and reproductive health, may be prohibited or censored under overbroad legislation.<sup>14</sup> The Special Rapporteur has noted that "[w]omen and girls are most likely to be affected by this gap in available services and programming because they are exposed to a higher risk of HIV/AIDS and sexually transmitted infections, maternal mortality, unsafe abortion and unwanted or unplanned pregnancies."<sup>15</sup>

The Special Rapporteur has further confirmed that criminal and other laws restricting access to comprehensive sexual and reproductive health information are incompatible with the full realization of the right to health.<sup>16</sup> In turn, the Special Rapporteur has explicitly called upon states to "[d]ecriminalize the provision of information relating to sexual and reproductive health, including evidence-based sexual and reproductive health education . . . ."<sup>17</sup>

## 2.3 SEX WORK

The act of exchanging sex for remuneration is both directly and indirectly criminalized in almost every national context. In addition to explicitly criminalizing the sale and/or purchase of sex, states criminalize a wide range of activities around sex work through laws that punish "living off the proceeds of prostitution," brothel keeping, promotion of another persons' engagement in sex work, letting premises for the purpose of sex work, solicitation and/or loitering for an "immoral purpose," and advertising for sex work, among other things. While states have an obligation to take action against those who force people to sell sex, individuals who are forced to sell sex or who choose to sell sex all too often face the punitive impact of criminal regimes, at times, in violation of their human rights.

The enforcement of criminal laws against sex workers<sup>18</sup> can lead to forced evictions, arbitrary arrests, investigations, surveillance, prosecutions and severe punishment.<sup>19</sup> In some contexts, criminal sex work

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<sup>13</sup> CRC, *supra* note 11, at Arts. 5, 14; CRC, General Comment 4 (Adolescent Health), *supra* note 11, at paras. 7, 16.

<sup>14</sup> See 2011 Report of the Special Rapporteur on the Right to Health, *supra* note 6, at para.62.

<sup>15</sup> *Id.*

<sup>16</sup> See *id.* at para. 56 (citing UN Committee on Economic, Social and Cultural Rights, General Comment 14 (Right to Health), U.N. Doc. E/C.12/2000/14, para. 11 (2000) [hereinafter CESCR, General Comment 14]).

<sup>17</sup> 2011 Report of the Special Rapporteur on the Right to Health, *supra* note 6, at para. 65 (e).

<sup>18</sup> For purposes of this submission, Amnesty International uses the term "sex worker" to refer to an individual who chooses to exchange sex acts for money or some other form or remuneration (*i.e.*, food or shelter). The term is intended to be gender neutral, as men and women and transgender people engage in sex work.

<sup>19</sup> See Human Rights Watch, *Sex Workers at Risk: Condoms as Evidence of Prostitution in Four U.S. Cities* (2012); M.H. Wurth *et al.*, *Condoms as Evidence of Prostitution in the United States and the Criminalization of Sex Work*, 16 JOURNAL OF THE INTERNATIONAL AIDS SOCIETY 18626 (2013); *Stonewalled: Police Abuse and Misconduct against Lesbian, Gay, Bisexual and Transgender People in the United States*, Amnesty International AMR 51/122/2005; *Risks, Rights & Health*, *supra* note 6; UNDP (Asia-Pacific Regional Centre) and UNFPA (Asia Pacific Regional Office), UNAIDS and the Asia Pacific Network of Sex Workers (APNSW), *Sex Work and the Law in Asia and the Pacific: Laws, HIV and Human Rights in the Context of Sex work* (October

and public nuisance laws also create an enabling environment for police and others to commit extortion and engage in harassment and violence against sex workers with impunity.<sup>20</sup> “Rescue” raids of sex establishments by police can also result in abuses against sex workers and lead to their dispersal from safer working environments.<sup>21</sup> Criminalization of sex work and resulting stigma and violence has also been shown to impact sex workers’ access to health services, including sexual and reproductive health services and HIV treatment and prevention.<sup>22</sup> This impact may be further compounded when exposure, non-disclosure and transmission of HIV are also criminalized.<sup>23</sup>

It therefore appears that sex workers are experiencing violence and rights violations at the hands of law enforcement and non-state actors in criminalized regimes. Moreover, it appears that those who sell sex (often women) face a disproportionate impact of policing and punishment. To that end, the Working Group may consider taking up this issue as one form of discrimination against women in law and practice.

Notably, the criminalization of sex work is increasingly being recognized as a human rights concern. Additionally, the UN Special Rapporteur on the Right to Health has explicitly called for decriminalization of sex work.<sup>24</sup> The final report of the Global Commission on HIV and the Law, an independent body convened by the UN Development Programme (UNDP) on behalf of the Joint United Nations Programme on HIV/AIDS (UNAIDS), has made the same call.<sup>25</sup> The Commission deliberated over a two-year period, undertaking extensive analysis and research, including seven regional dialogues, on the links between legal frameworks, human rights and HIV.

The UNAIDS Advisory Group on HIV and Sex Work has also recommended that states move away from criminalizing sex work and associated activities, and emphasized that decriminalization of sex work should include removing criminal penalties for purchase and sale of sex, management of sex workers and brothels, and other activities related to sex work.<sup>26</sup> The UNAIDS Advisory Group has further recommended that states that retain non-criminal administrative law or regulations concerning sex work

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2012); UN Women, Note on Sex Work, Sexual Exploitation and Trafficking (9 October 2013)]; WHO, UNFPA, UNAIDS, *Prevention and Treatment of HIV and other STIs for Sex Workers in Low and Middle Income Countries: Recommendations for a Public Health Approach* (December 2012).

<sup>20</sup> See *Risks, Rights & Health*, *supra* note 6, at 37; WHO, *Violence Against Women and HIV/AIDS: Critical Intersections, Violence against Sex Workers and HIV Prevention*, Information Bulletin Series, No. 3 (2005); Women’s Network of Unity, *Violence Against Sex Workers is Prevalent in Cambodia With Customers and the Police Often the Perpetrators* (2011).

<sup>21</sup> In India and Indonesia, researchers have found that sex workers who were rounded up in raids were beaten, coerced into sex by police, and placed in institutions where they were sexually exploited and otherwise suffered physical abuse. See R. Surtees, *Brothel Raids in Indonesia—Ideal Solution or Further Violation?*, 6 RESEARCH FOR SEX WORK 5-7 (2003); Sangram, Point of View, and VAMP, *Rehabilitation: Against Their Will? Of Veshyas, Vamps, Whores and Women: Challenging Preconceived Notions of Prostitution and Sex Work* (2002).

<sup>22</sup> See WHO, UNFPA, UNAIDS, NSWP and World Bank, *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions* 23, 24 and 27 (2013), available at [http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf) (last accessed 28 April 2015) [hereinafter *Implementing Comprehensive HIV/STI Programmes with Sex Workers*]; Anna Forbes and Sarah Elspeth Patterson, *The Evidence Is In: Decriminalizing Sex Work Is Critical to Public Health*, RH REALITY CHECK (2014), available at <http://rhrealitycheck.org/article/2014/08/13/evidence-decriminalizing-sex-work-critical-public-health/> (last accessed 28 April 2015).

<sup>23</sup> See *Implementing Comprehensive HIV/STI Programmes with Sex Workers*, *supra* note 23, at 24; see also UNAIDS, *The Gap Report* 187-198 (2014), available at [http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS\\_Gap\\_report\\_en.pdf](http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf) (last accessed 28 April 2015); Kate Shannon and Stephanie Strathdee, *et. al.*, *Global Epidemiology among Female Sex Workers: The Influence of Structural Determinants*, 385 THE LANCET 55 (2015).

<sup>24</sup> See 2010 Report of the Special Rapporteur on the Right to Health, *supra* note 6, at 46-50.

<sup>25</sup> “Rather than punishing consenting adults involved in sex work, countries must ensure safe working conditions and offer sex workers and their clients’ access to effective HIV and health services and commodities. Countries must: Repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against “immoral” earnings, “living off the earnings” of prostitution and brothel-keeping. Complementary legal measures must be taken to ensure safe working conditions to sex workers.” *Risks, Rights & Health*, *supra* note 6, at 43.

<sup>26</sup> See UNAIDS Advisory Group on HIV and Sex Work 7-9 Sept 2011 - Notes for Record 6 (2011), available at <http://www.nswp.org/resource/unaids-advisory-group-hiv-and-sex-work-7-9-sept-2011-notes-record> (last accessed 24 April 2015).

should ensure that these laws are applied in ways that do not violate sex workers' rights or dignity and that ensure their enjoyment of due process of law.<sup>27</sup>

UN Women has also confirmed its support for decriminalization of sex work "in order to ensure the access of sex workers to all services, including HIV care and treatment."<sup>28</sup> Moreover, the World Health Organization calls for all countries to "work toward decriminalization of sex work and elimination of the unjust application of non-criminal laws and regulations against sex workers."<sup>29</sup> Finally, the International Labour Organisation (ILO) has called on governments to recognize sex work as an economic sector and "a legal occupation with protection under labour law and social security and health regulations."<sup>30</sup>

## 2.4 CONDUCT IN PREGNANCY

The criminalization of conduct in pregnancy raises a number of human rights concerns. In some countries, the criminalization of abortion compromises services for women who have had miscarriages,<sup>31</sup> while in the USA, feticide, chemical endangerment, and assault laws criminalize women for engaging in behavior that may have the potential to harm their fetuses. Laws that render substance use during pregnancy a criminal offence can deter women from seeking essential prenatal care and can prevent them from feeling safe when going to a hospital for labour and delivery services.<sup>32</sup>

The threat of criminal liability may infringe upon pregnant women's rights to health, equality and non-discrimination, privacy, liberty and security of the person, and freedom from cruel, inhuman or degrading treatment or punishment. Along those lines, the UN Special Rapporteur on the Right to Health has affirmed that criminalization of conduct during pregnancy impedes access to healthcare goods and services, infringing the right to health of pregnant women. The Special Rapporteur has explicitly called for states to suspend the application of "existing criminal laws to various forms of conduct during pregnancy."<sup>33</sup>

In addition to laws specifically aimed at criminalizing conduct in pregnancy, feticide and abortion laws may similarly place women in a situation where they may be exposed to criminal prosecution as a result of seeking healthcare services. According to Amnesty International's research in Ireland, the 8th Amendment to Ireland's Constitution acknowledging the right to life of the "unborn," has significantly impacted the quality of non-abortion maternal health care that pregnant women receive in that country. For example, Amnesty International research found that health care providers have: withheld medically indicated treatment, including abortion, and waited for a pregnant woman's health to seriously deteriorate; refrained from providing suicidal women with critical mental health care and instead contributed to their mental suffering by denying them a lawful abortion; forced medical care upon pregnant women without their consent, enforced by court order; and kept a brain dead pregnant woman on life support, denying her the ability to die with dignity.<sup>34</sup>

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<sup>27</sup> See *id.*

<sup>28</sup> "UN Women also supports the regulation of sex work in order to protect sex workers from abuse and violence." UN Women, *Note on Sex Work, Sexual Exploitation and Trafficking* (2013).

<sup>29</sup> WHO, HIV/AIDS Programme, *Prevention and Treatment of HIV and Other Sexually Transmitted Infections for Sex Workers in Low- and Middle-Income Countries: Recommendations for a Public Health Approach* 8 (2012).

<sup>30</sup> Lin Lean Lim, *The Sex Sector: The Economic and Social Bases of Prostitution in Southeast Asia*, edited by, International Labour Office (ILO) (1998).

<sup>31</sup> "On the Brink of Death: Violence Against Women And The Abortion Ban in El Salvador" Amnesty international AMR 29/003/2014.

<sup>32</sup> This is confirmed by ongoing Amnesty International research on criminalization of conduct in pregnancy in the USA, which will be published in 2015.

<sup>33</sup> These restrictions can "violate the right to health by infringing human dignity by restricting the freedoms to which individuals are entitled under the right to health, particularly in respect of decision-making and bodily integrity. The application of such laws as a means to achieving certain public health outcomes is often ineffective and disproportionate." 2011 Report of the Special Rapporteur on the Right to Health, *supra* note 6, at 24.

<sup>34</sup> Forthcoming Amnesty international report to be issued June 2015.

Amnesty International's research in El Salvador also indicates that criminalization of abortion has substantial consequences for women suffering miscarriages.<sup>35</sup> Amnesty International met women who reported being treated with suspicion and contempt when seeking treatment for a miscarriage, including being harassed and accused of murder by medical staff. Sometimes healthcare personnel report women to the authorities, and interrogations by the police lead to homicide prosecutions. While states and society more broadly have an interest in ensuring safe pregnancies, this interest cannot subsume the interests and human rights of pregnant women.

### 3. CONSCIENTIOUS OBJECTION TO ABORTION

The practice of "conscientious objection" to abortion services is rising across the globe.<sup>36</sup> UN Treaty Bodies have specifically recognized "conscientious objection" as a barrier to accessing reproductive health services, and have issued recommendations to a range of countries on the issue.<sup>37</sup> The Treaty Bodies have generally stated that governments have a positive obligation to ensure that the application of "conscientious objection" clauses does not violate women's right to access to quality, affordable and acceptable sexual and reproductive health care services, including abortion.<sup>38</sup> The Treaty Bodies have also specifically confirmed states' obligations to ensure that women are referred to alternative providers in the event health care providers assert "conscientious objection" in the course of their work.<sup>39</sup> The CEDAW has specifically stated that the exercise of "conscientious objection" is limited to individuals, confirming that institutions have no such right.<sup>40</sup> Additionally, "conscientious objection" cannot be invoked in emergency situations where life-saving treatment is necessary.<sup>41</sup>

Other UN Treaty Bodies have also called on state parties to adequately regulate the practice of "conscientious objection." For example, in 2010, the Human Rights Committee addressed this issue in the context of the ICCPR's right to life provision. In monitoring Poland's compliance with the treaty, the Committee raised concerns "that, in practice, many women are denied access to reproductive health services, including contraception counselling, prenatal testing and lawful interruption of pregnancy" and recommended that Poland "introduce regulations to prohibit the improper use and performance of the 'conscience clause' by the medical profession."<sup>42</sup> The growing recognition of the problem is evidenced by the Committee against Torture taking up the issue. In December 2013, this Committee issued its first ever concluding observation on "conscientious objection."<sup>43</sup>

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<sup>35</sup> See *On the Brink of Death: Violence Against Women And The Abortion Ban in El Salvador* Amnesty international AMR 29/003/2014.

<sup>36</sup> See *generally* INTERNATIONAL JOURNAL OF GYNECOLOGY AND OBSTETRICS, Vol. 123, Supp. 3, 50 (2013).

<sup>37</sup> See, e.g., Concluding Observations of the Committee on the Elimination of Discrimination against Women: Croatia, U.N. Doc. A/53/38, para. 109 (1998); Italy, U.N. Doc. A/52/38 Rev.1, para. 353 (1997); Poland, U.N. Doc. CEDAW/C/POL/CO/6, para. 25 (2007); Concluding Observations of the Human Rights Committee: Poland, U.N. Doc. CCPR/CO/82/POL, para. 8 (2004) [hereinafter Concluding Observations HRC: Poland (2004)]; Concluding Observations of the Committee on Economic, Social and Cultural Rights: Poland U.N. Doc. E/C.12/POL/CO/5, para. 28 (2009).

<sup>38</sup> See, e.g., Concluding Observations of the Committee on the Elimination of Discrimination against Women: Slovakia, U.N. Doc. A/63/38, paras. 42-43 (2008) [hereinafter Concluding Observations CEDAW: Slovakia (2008)]; Concluding Observations HRC: Poland (2004), *supra* note 38, at para. 8.

<sup>39</sup> Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 (women and health), (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies (Vol. II), at 358, para. 11, U.N. Doc. A/HRI/GEN/1/Rev.9 (2008); Concluding Observations CEDAW: Slovakia (2008), *supra* note 39, at para. 43.

<sup>40</sup> See Concluding Observations of the Committee on the Elimination of Discrimination against Women: Hungary, U.N. Doc. CEDAW/C/HUN/CO/7-8, paras 30-31 (2013).

<sup>41</sup> See Wendy Chavkin, Liddy Leitman and Kate Polin, *Conscientious Objection to the Provision of Reproductive Healthcare: A White Paper Considering Prevalence, Health Consequences and Policy Responses*, INTERNATIONAL JOURNAL OF GYNECOLOGY AND OBSTETRICS, Vol. 123, Supp. 3, 50 (2013).

<sup>42</sup> Concluding Observations of the Human Rights Committee: Poland, U.N. Doc. CCPR/C/POL/CO/6, para. 12 (2010).

<sup>43</sup> See Concluding Observations of the Committee Against Torture: Poland, U.N. Doc. CAT/C/POL/CO/5-6 (2013).



The UN Special Rapporteur on the Right to Health issued a report in 2011 that highlighted the negative impact of criminalization of abortion on women's health and lives, and set forth detailed standards on the issue.<sup>44</sup> The report notes that "conscience clauses" and their use create barriers to access by permitting health care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures, and referrals to alternative facilities and providers. The Special Rapporteur noted that these and other laws make safe abortions unavailable, especially to poor, displaced and young women, and emphasized that such restrictive regimes serve to reinforce the stigma that abortion is an objectionable practice. He recommended that states, in order to fulfill their obligations under the right to health, should "ensure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider."<sup>45</sup>

It would be useful if the Working Group reinforced the recommendations of the UN Special Rapporteur and reaffirmed the restrictions on who can invoke "conscientious objection" and in what circumstances. For example, a health care provider can only object to the direct provision of services, which does not include providing information on the diagnosis or prognosis or any other information related to one's pregnancy, regardless of whether the provider believes the patient will act in way that is objectionable. The right to information on one's health status is an essential component to the realization of the right to health, as well as other rights. In addition to confirming that states have an obligation to ensure that women are referred to other providers, they must also organize their health systems in a way that ensures that women can obtain health services to which they are legally entitled.<sup>46</sup> This includes making sure there are an adequate number of health care providers within reasonable access to provide abortions. Finally, healthcare institutions have no right to invoke "conscientious objection;" rather this is a right reserved to individual healthcare providers directly involved with the provision of services.

#### 4. GUARANTEEING RAPE VICTIMS EQUAL AND UNOBSTRUCTED ACCESS TO EMERGENCY HEALTH CARE INFORMATION, SERVICES AND GOODS

The Working Group may also consider highlighting and consolidating the international standards on access to post-rape health care, and explicitly referencing that this spectrum of healthcare information, goods and services not only form part of the minimum core obligations of states,<sup>47</sup> but are also a form of emergency health care to which each victim must have guaranteed equal access to. Post-rape health care must be available, accessible, acceptable and of quality. What this means in practice is that states have a positive obligation to reform and establish human rights respecting and guaranteeing frameworks, that information is available, that cost, distance, and other barriers to access, such as discriminatory laws and policies, are addressed as a matter of priority.

The Working Group's report provides an opportunity to explicitly address a number of key issues, including the removal of user fees to guarantee all rape victims can manage the consequences of the violation they have endured. In the case of emergency contraception, it would be welcome if the Working Group reaffirmed the position taken by the Committee on the Rights of the Child, for example, in its Concluding Observations to Costa Rica, where it urged the state to "[e]nsure that girls and adolescents have free and timely access to emergency contraception and raise awareness among

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<sup>44</sup> See 2011 Report of the Special Rapporteur on the Right to Health, *supra* note 6.

<sup>45</sup> *Id.*

<sup>46</sup> *P and S v. Poland*, ECtHR, Application no. [57375/08](#), para 106 (2012), *RR v. Poland*, ECtHR, Application no. [27617/04](#) para 206 (2011).

<sup>47</sup> Post rape health care forms part of states' minimum core obligations, as reflected in the General Comment 14 of CESCR, which conveys "minimum core" comparable priority to the provision of sexual and reproductive health care for women and girls. See CESCR, General Comment 14, *supra* note 17, at para. 44 (a).

women and girls about their right to emergency contraception, particularly in cases of rape.”<sup>48</sup> Further, the Committee against Torture, in its Concluding Observations on Peru in 2012, found that denial of safe and cost free abortion services to rape victims constituted a breach of women’s and girls’ rights to reparation under Article 14, and their right to be free from cruel, inhuman and degrading treatment under Article 16 of the Convention against Torture.<sup>49</sup> Notably, in its Precautionary Measures issued to Haiti after the earthquake, the Inter-American Commission on Human Rights ordered that women and girls victims of rape be guaranteed access to HIV prophylaxis and emergency contraception in order to be able to mitigate some of the impacts of sexual violence.<sup>50</sup>

It would also perhaps be useful to underline the fundamental human rights of women and girls victims of rape that are violated when they are denied access to HIV and STI prophylaxis, emergency contraception and safe and legal abortion services.

The UN Committee on Economic, Social and Cultural Rights (CESCR) has also confirmed in its General Comment 14 (Right to Health) that, “States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, . . . to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women’s health status and needs.”<sup>51</sup>

The health system is often recognized as the first – and sometimes the only – port of call for rape victims.<sup>52</sup> To that end, the WHO recommends that post-rape health care services are provided and integrated into the primary health care level services, so that it is as accessible as possible. The WHO also recommends that post-rape and gender-based violence care provided is “non-judgemental and supportive and validating.”<sup>53</sup> Amnesty International’s research on the response by officials in the health system to rape victims coincides with other experts’ findings that it is lacking and in some cases re-victimizes women and girls seeking assistance.<sup>54</sup>

As referenced earlier, “conscientious objection” is recognized as a notable obstacle to accessing health care in the context of women’s and girls’ sexual and reproductive health and the services they need and have a right to. States have a positive obligation to regulate “conscientious objection” as it affects women and girls accessing healthcare services that only they need. This has been highlighted by the UN Treaty Bodies and Special Procedures on numerous occasions and is a well-established standard. “Conscientious objection” by health care providers has been found to only be permitted insofar as the person seeking care can still be guaranteed timely and appropriate quality care and cannot be invoked in emergency situations. For example, in his 2011 report to the United Nations General Assembly, the

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<sup>48</sup> Concluding Observations of the Committee on the Rights of the Child: Costa Rica, U.N. Doc. CRC/C/CR/CO/4, para. 64(e) (2011).

<sup>49</sup> Concluding Observations of the Committee against Torture: Peru, U.N. Doc. CAT/C/PER/CO/5-6, para. 15 (2013) (“The State party should review its legislation with a view to: (a) Amending the general prohibition for cases of therapeutic abortion and pregnancy resulting from rape and incest and provide free health coverage in cases of rape.”)

<sup>50</sup> See Inter-American Commission on Human Rights, Precautionary Measures MC-340-10, Haiti, 2010 and, further, the Inter-American Commission on Human Rights (IACHR) has frequently underlined the nature of states’ legal obligations in relation to the provision of post rape health care. For example, in *Paulina del Carmen Ramírez Jacinto v. Mexico*, Case 161-02, Report No. 21/07, Inter-Am. C.H.R., OEA/Ser.LN/II.130 Doc. 22, rev. 1 (2007) the IACHR stated: “The Commission also underscores that women cannot fully enjoy their human rights without having a timely access to comprehensive health care services, and to information and education in this sphere. The IACHR also notes that the health of sexual violence victims should be treated as a priority in legislative initiatives and in the health policies and programs of Member States.”

<sup>51</sup> CESCR, General Comment 14, *supra* note 17, para. 34.

<sup>52</sup> See World Health Organisation Guidelines for Responding to Intimate Partner Violence and Sexual Violence Against Women (2013).

<sup>53</sup> World Health Organisation Guidelines for Responding to Intimate Partner Violence and Sexual Violence Against Women, 3 (2013).

<sup>54</sup> See, for example, “*Listen to their voices and act: stop the rape and sexual abuse of girls in Nicaragua*”, Amnesty International AMR 43/008/2010, and “*This is what we demand: Justice! Impunity for sexual violence against women in Colombia’s Armed Conflict*”, Amnesty International AMR 23/018/2011.

Special Rapporteur on the Right to Health cites inadequate regulation of “conscientious objection” as a legal restriction that contributes to making legal certain health care only required by women and girls inaccessible.

In the context of post-rape health care provision, unregulated “conscientious objection” turns the health system into a lottery for victims meaning some will be denied timely access to the full spectrum of information, services and goods, leading to further violations of their fundamental human rights. In a context where “conscientious objection” is permitted in the provision of post-rape services, each victim is entirely dependent on the inclination of the particular health professional they see to provide the services they need. Given the serious violations that women and girls suffer if there are delays or obstacles that prevent timely information about, and access to, emergency contraception, HIV/STI prophylaxis and safe and legal abortion services, states must regulate this service provision to ensure women and girls are guaranteed equal access to the full constellation of care, and that it is provided as essential emergency medical assistance. Medical protocols, policies and laws must guarantee that post-rape health care is provided - as it should be - as emergency medical assistance, in an obligatory and priority fashion, and that the training and provision of health care providers would also be congruent with this.

## 5. TRANSGENDER PEOPLE'S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE AND INFORMATION

Transgender individuals experience violations of their right to health, both in obtaining gender-affirming treatment and sexual and reproductive health care more broadly, as a result of laws and policies that prevent access to services, and health professionals’ prejudice or lack of knowledge about transgender people’s health care needs. Notably, health care providers may assume that transgender people do not need access to contraception and safe abortion services.<sup>55</sup>

The UN High Commissioner for Human Rights has noted that “[i]n many countries, transgender persons face particular difficulties in their access to health care. Gender reassignment therapy, where available, is often prohibitively expensive and State funding or insurance coverage is rarely available. Health-care professionals are often insensitive to the needs of transgender persons and lack necessary professional training.”<sup>56</sup> Problematic treatment by medical staff, outdated approaches to gender identity and expression, and lack of knowledge and facilities lead to mistrust and in many cases, to the violation of the individuals’ right to the highest attainable standard of health.

The Yogyakarta Principles affirm that “[n]o person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person’s sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed.”<sup>57</sup>

Along similar lines, transgender individuals who wish to change the name and/or gender that they were assigned at birth face significant legal, social and institutional hurdles. Stipulations for legal gender recognition - where they exist - often require the individual to be diagnosed with a mental disorder or

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<sup>55</sup> See generally Alex Müller, Gender Dynamix, *Sexual and Reproductive Health for Transgender and Gender Non-conforming People: Guidelines for Health Care Workers in Primary Care* (2013); National Center for Transgender Equality, *Transgender Sexual and Reproductive Health: Unmet Needs and Barriers to Care* (2012), available at [http://transequality.org/sites/default/files/docs/resources/Factsheet\\_TransSexualandReproHealth\\_April2012.pdf](http://transequality.org/sites/default/files/docs/resources/Factsheet_TransSexualandReproHealth_April2012.pdf) (last accessed 4 May 2015).

<sup>56</sup> 2011 Annual Report of the OHCHR, *supra* note 9, at para. 57.

<sup>57</sup> The Yogyakarta Principles, Principle 18 (Protection from Medical Abuses), available at [http://www.yogyakartaprinciples.org/principles\\_en\\_principles.htm](http://www.yogyakartaprinciples.org/principles_en_principles.htm) (last accessed 5 May 2015). The Yogyakarta Principles are a set of principles on the application of international human rights law in relation to sexual orientation and gender identity. The Principles affirm binding international legal standards with which all States must comply. See About the Yogyakarta Principles, available at [http://www.yogyakartaprinciples.org/principles\\_en\\_about.htm](http://www.yogyakartaprinciples.org/principles_en_about.htm) (last accessed 4 May 2015).

undergo genital reassignment surgery - clear violations of the right to the highest attainable standard of health. In a number of countries, transgender people seeking recognition of their gender must undergo sterilization - this requirement has been opposed by the UN Special Rapporteur on Torture.<sup>58</sup>

## 6. THE IMPACT OF INTERSECTIONAL DISCRIMINATION ON WOMEN'S AND GIRLS' HEALTH AND SAFETY

The principle of non-discrimination is fundamental to the realization of human rights. This is evidenced by the existence of non-discrimination provisions in every international human rights instrument and the mandate of the Working Group. While human rights experts and monitoring bodies initially analysed the bases of discrimination separately, there is increasing recognition of the ways in which various bases of discrimination overlap and intersect, leading to distinct forms of discrimination that impact particular groups and individuals. For example, the CESCR has noted that “[s]ome individuals or groups of individuals face discrimination on more than one of the prohibited grounds, for example women belonging to an ethnic or religious minority. Such cumulative discrimination has a unique and specific impact on individuals and merits particular consideration and remedying.”<sup>59</sup> It would be helpful if the Working Group addresses intersectional discrimination in its upcoming report, highlighting states’ obligations to ensure that laws and policies, especially those that appear to be neutral, do not have a discriminatory impact on women and girls from particular sections of the population.

As referenced earlier, laws that criminalize sexual and reproductive actions and decisions often more severely impact individuals from groups suffering multiple forms of discrimination. For example, criminal abortion laws disproportionately affect the poorest women and girls who do not have the means to travel to a country where abortion is legal. Often the poorest women and girls belong to minority groups or Indigenous peoples or are migrants or asylum seekers who also lack documentation to enable them to travel.

Likewise, laws criminalizing conduct in pregnancy often disparately impact the most marginalized women who have limited access to quality healthcare, drug treatment, and the services and support they need to achieve healthy pregnancies and birth outcomes. For example, barriers to women and girls from Indigenous or minority groups accessing quality healthcare may include distance from service providers and cost of getting there, language spoken by healthcare staff or discriminatory attitudes by healthcare staff.<sup>60</sup> Health care services must be accessible to all without discrimination “especially [for] the most vulnerable and marginalized sections of the population.”<sup>61</sup>

In addition to providing access to services for survivors of rape and other forms of sexual violence without discrimination States also have the obligation to take measures to prevent such violence. In situations of displacement, whether due to conflict or natural disaster, refugee and internally displaced women and girls face increased rates of sexual violence. Camps for displaced persons are often insecure with women and girls being targeted for rape and other forms of sexual violence while collecting water or other supplies or when using toilet facilities.<sup>62</sup> Amnesty International spoke to disabled women living in internally displaced persons (IDP) camps in Somalia who had been specifically targeted and raped because they were disabled; their attackers had perceived them as “vulnerable.”<sup>63</sup> As discussed earlier, states must ensure that survivors of violence have access to all

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<sup>58</sup> Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/22/53, 1 February 2013, para. 78.

<sup>59</sup> Committee on Economic, Social and Cultural Rights, General Recommendation 20 (Non-discrimination in Economic, Social and Cultural Rights), U.N. Doc. E/C.12/GC/20, para. 17 (2009)

<sup>60</sup> “On the Brink of Death: Violence Against Women And The Abortion Ban in El Salvador” Amnesty International AMR 29/003/2014; Paltrow and Flavin, *Arrests and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women’s Legal Status and Public Health*, JOURNAL OF HEALTH POLITICS, POLICY AND LAW (2013).

<sup>61</sup> CESCR, General Comment 14, *supra* note 17, at para. 12(b).

<sup>62</sup> “Aftershocks: Women speak out against sexual violence in Haiti’s camps”, Amnesty International AMR 36/001/2011; “Rape and sexual violence in Somalia – an ongoing epidemic”, Amnesty International AFR 52/009/2013.

<sup>63</sup> “Somalia: Prioritise protection for people with disabilities”, Amnesty International, AFR 52/1166/2015.

appropriate post-rape healthcare. Additionally, states have the obligation to prevent violence by taking measures to ensure safety and security within camps for refugees or internally displaced persons with a particular focus on identifying and remedying risks to the safety of women and girls.

Indigenous or minority women and girls may also experience multiple forms of discrimination because of their gender and their membership of an Indigenous or minority group, resulting in them being targets of rape or other forms of sexual violence or even murder at higher rates than other women and girls. For example, Indigenous women in Canada disappear and are murdered at more than four times the rate of non-Indigenous women and girls. The legacy of colonialism has resulted in racist and sexual stereotypes about the sexuality of Indigenous women. The Inter-American Commission on Human Rights has stressed that “addressing violence against indigenous women is not sufficient unless the underlying factors of racial and gender discrimination that originate and exacerbate the violence are also comprehensively addressed.”<sup>64</sup>

Ensuring the health and safety of women and girls, especially those from groups experiencing intersectional discrimination, requires States to address underlying stereotypes and discriminatory attitudes that encourage, condone or make gender-based violence more likely.

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<sup>64</sup> Canada, Submission to the Pre-sessional Working Group of the Committee on Economic, Social and Cultural Rights, Amnesty International AMR 20/1143/2015; “No More Stolen Sisters: The need for a comprehensive response to discrimination and violence against Indigenous women in Canada”, Amnesty International AMR 20/012/2009. The Inter-American Commission has called for action to tackle the root causes of their exposure to higher risks of violence. Canada has yet to implement recommendation from numerous UN bodies to develop a comprehensive, coordinated national plan of action, including a nationwide inquiry, and improvements in data collection on violence against Indigenous women.