**QUESTIONNAIRE**

**“Violence and its impact on the right to health”**

**Contact Details**

Please provide your contact details in case we need to contact you in connection with this survey. Note that this is optional.

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| --- | --- |
| Type of Stakeholder (please select one) | Member State  Observer State  X Other Civil Society Organization |
| Name of State  Name of Survey Respondent | Ipas |
| Email | gallib@ipas.org |
| Can we attribute responses to this questionnaire to your State publicly\*?  \*On OHCHR website, under the section of SR health | Yes X No  Comments (if any): The questionnaire is related to Latin American region and the impact of criminal abortion laws in contexts of high rates of GBV against women and girls and state failure of its duty to provide effective measures of reparations including access to safe abortion care to avoid re-victimization and perpetuation of violence cycle. |

# Key questions

*You can choose to answer all or some of the questions below. (750 words limit per question).*

When responding to the questions below, please use the glossary with definitions at the end of the questionnaire, and refer to all or some of the forms of violence in focus for this study as applicable in your country, countries or region in focus:

1. Please describe, share data and information on the characteristics, number of cases, and the profile of victims and perpetrators in your country/ies or region(s) regarding:
   1. gender based violence against women

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

Population-level surveys based on reports from survivors provide the most accurate estimates of the prevalence of intimate partner violence and sexual violence. A 2018 analysis of prevalence data from 2000-2018 across 161 countries and areas, conducted by WHO on behalf of the UN Interagency working group on violence against women, found that worldwide, nearly 1 in 3, or 30%, of women have been subjected to physical and/or sexual violence by an intimate partner or non-partner sexual violence or both .

Over a quarter of women aged15-49 years who have been in a relationship have been subjected to physical and/or sexual violence by their intimate partner at least once in their lifetime (since age 15). The prevalence estimates of lifetime intimate partner violence range from 20% in the Western Pacific, 22% in high-income countries and Europe and 25% in the WHO Regions of  the Americas to 33% in the WHO African region, 31% in the WHO Eastern Mediterranean region, and 33% in the WHO South-East Asia region.

Globally as many as 38% of all murders of women are committed by intimate partners. In addition to intimate partner violence, globally 6% of women report having been sexually assaulted by someone other than a partner, although data for non-partner sexual violence are more limited. Intimate partner and sexual violence are mostly perpetrated by men against women.

Lockdowns during the COVID-19 pandemic and its social and economic impacts have increased the exposure of women to abusive partners and known risk factors, while limiting their access to services. Situations of humanitarian crises and displacement may exacerbate existing violence, such as by intimate partners, as well as non-partner sexual violence, and may also lead to new forms of violence against women.

* 1. gender based violence and other forms of violence against children:

Latin America is the only region where the number of births to girls under 15 has increased. The countries identified with the highest number are Mexico, Guatemala, Nicaragua, Peru, Ecuador and Paraguay. In Peru, according to figures from the National Institute of Statistics of 2017, four births of mothers under the age of 15 are registered every day, 99% of them are poor. According to a survey carried out in Brazil, most women affected by the Zika virus had their first pregnancy in adolescence, between the ages of 13 and 17, and almost half of them did not use any method to avoid a new pregnancy, even though none of them indicated that they were planning to have one. new child at that time.

As the UNFPA points out, teenage pregnancy at any age (up to 19 years old) makes it difficult for the most vulnerable young women to access education and employment opportunities, reproducing the conditions of poverty and exclusion in which they live. The younger the teenager, these conditions worsen and involve greater risks that it is not a consensual relationship, a greater lack of information and greater complications for the health of the mother and child, including a greater possibility of dying.

Prioritizing at the beginning of adolescence implies recognizing not only the geographic barriers, but also the lack of knowledge that exists at this stage, since, although the average of women starts their sexual life between 14 and 15 years old, few women do it in a context informed. and safe and even less access to sexual and reproductive health services. Several national reports and statistics show that the majority of actions are concentrated on older adolescents, which often means that this age group is arrived late, ignoring the number of pregnancies at an early age.

1. Please also share information on the impact of criminalization of sex work, same sex relations, transgender persons, abortion, drug abuse, harmful practices in obstetric care, female genital mutilation on the violence experienced by the affected individuals and their enjoyment of the right to health.

Lack of access to safe abortion care remains a challenge in Latin America region for GBV victims

In countries with restrictive abortion laws or even when abortion is legal but highly stigmatized, women and girls face considerable difficulties in accessing legal abortion services due to administrative and bureaucratic obstacles, the refusal on the part of health professionals to respect medical protocols that guarantee rights, as well as negative attitudes and official incompetence or disinterest (A / HRC / 22/53). Denying access to safe abortion and subjecting women and girls to humiliating and sententious attitudes in those situations of extreme vulnerability and in which it is essential to access health care within the time limit amounts to torture and ill-treatment (UNFPA, 2019).

According to the Committee on Economic Social and Cultural Rights General Comment 22:

1. States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of the right to sexual and reproductive health. In this regard, States parties should be guided by contemporary human rights instruments and jurisprudence,[[1]](#footnote-1) as well as the most current international guidelines and protocols established by the UN agencies, in particular WHO and UNFPA.[[2]](#footnote-2) The core obligations include at least the following:

(…)

(h) To ensure access to effective and transparent remedies and redress, including administrative and judicial ones, for violations of the right to sexual and reproductive health.

Access to safe abortion and other reproductive health services remains a challenge to women, girls and pregnant people, and this gap shows us that even with progress on maternal care worldwide, it has not necessarily been accompanied by progress in all essential areas of women’s sexual and reproductive health and rights (A/74/137).

1. Please share information on the health and other type of responses provided by the State and/or other actors in your country/ies or regions in focus to survivors of each/some of the aforementioned forms of violence. Please assess what works well and not so well, and whether COVID-19 impacted the response and how.

The treatment of women as full citizens with the right to equal protection before the law includes revising abortion laws that discriminate and criminalize them and transparent access to legally authorized and available health care services.

In the case of Paulina del Carmen Ramírez Jacinto v. Mexico, the parties have signed a friendly settlement before the IACHR. The State violated the human rights of an adolescent rape victim by denying her access to abortion services to which she was legally entitled. Among the measures of comprehensive reparation agreed, was the recognition of the lack of an adequate legal framework on the part of the Baja California government so that women can exercise their right to terminate a pregnancy resulting from rape. It was from this precedent that normative reforms were achieved that allowed important advances in the field of women's reproductive rights in this region in Mexico and then more broadly at national level.

The right of women to access comprehensive reproductive health services, including abortion, is rooted in international human rights standards that guarantee the right to life, health, privacy, and freedom from discrimination.

Women and girls who become pregnant as a result of rape are more likely to experience further abuses of their rights. In addition to the trauma of the rape itself, there are the difficulties of having and caring for a child as a result of violence.

The refusal to provide services due to the social stigma derived from the criminalization of the voluntary interruption of pregnancy may point to a situation of discrimination based on race or sex, age, socio-economic condition, by the health and justice systems and generate international responsibility for the breach of the duty to respect and protect the human rights of victims of gender violence.

Health and psychosocial care demands are very frequent in these cases, and they should be part of the comprehensive measures of reparations. In addition to the physical health consequences of gender-based violence there is also mental health impact. Among the comprehensive reparation measures, it is necessary to guarantee services that provide sustained support over time, with sufficient resources for adequate therapeutic accompaniment, respecting the confidentiality and privacy of the victims.

In humanitarian crisis situations, in situations of political conflict, in epidemics, or such as the current Covid 19 pandemic, more broad analysis of women's life circumstances and factors that may direct them to look for terminating a pregnancy should be adopted. For example, administrative proceedings of medical verification of their reasons based on physical or mental illness or impairment of fetal development should not be used to delay or impede their access. It would be enough to detect that the state of well-being, or the continuity of the woman's life project, has been harmed by the continuity of the pregnancy in a pandemic crisis. In these cases, the continuation of the pregnancy has the potential to cause deep mental suffering and anguish to the woman, regardless of the aggravation or not of the risks associated with her physical health.

When access to abortion can save the life or preserve the health of the woman, it is a therapeutic abortion. The decision about the legal interruption of pregnancy is an individual decision of each woman that must be respected, protected and guaranteed through laws, policies and health practices aimed at her well-being, physical, mental and social health. In general, therapeutic abortion aims to preserve the health of the woman in its physical, mental and social dimensions according to WHO definition of health.

1. Please describe the needs of survivors of the abovementioned forms of violence as identified by your State/institution. Please share survivor-self identified needs and those of their families, with a focus on health emergency and long-term needs.

Ipas is an international organization that works in more than 20 countries across Africa, Asia and Latin America to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. We envision a world where everyone can make their own sexual and reproductive choices, and ultimately, determine their own future.

By not ensuring the well-being of those who are pregnant and want termination, whether victims of sexual violence, or in other circumstances, and denying access to health services desperate needed by them, due to restrictive abortion laws, most States in Latin American countries incurs in violation of their rights and re-victimization. By re-victimization we argue that criminalizing abortion in first place already violate their rights and discriminates them de jure. Secondly the state deny access even in circumstances that infringe mental suffering and serious distress, maintaining de facto discrimination or in the application of the law in practice in their lives, maintaining their life projects constraints.

The concept of reparation is broad and is not only material but also immaterial and can contemplate other non-repetition measures by the State, such as, for example, the adoption of a specific law, a health protocol or raise awareness campaign on the issue of sexual violence against girls.In countries with restrictive abortion laws or even when abortion is legal but highly stigmatized, women and girls face considerable difficulties in accessing legal abortion services due to administrative and bureaucratic obstacles, the refusal on the part of health professionals to respect medical protocols that guarantee rights, as well as negative attitudes and official incompetence or disinterest (A / HRC / 22/53). Denying access to safe abortion and subjecting women and girls to humiliating and sententious attitudes in those situations of extreme vulnerability and in which it is essential to access health care within the time limit amounts to torture and ill-treatment .

States have an affirmative obligation to reform restrictive abortion laws or implement the full extent of existing abortion laws to avoid perpetuation of torture and ill-treatment by systematic lack of access to women and girls and persons with the capacity to safe abortion and care. The limitations or conditionality of access to medical care for abortions remains a matter of concern, especially when such care is denied for the intolerable purpose of imposing punishment or obtaining a confession (A / HRC / 22/53). In particular, the practice of obtaining confessions, for use in trials, from women who require urgent medical assistance after having a clandestine abortion constitutes torture or ill-treatment.

In relation to girls who are victims of sexual violence, forced pregnancy and motherhood produces burdensome costs since it affects the life trajectories of girls, due to school dropouts, job insecurity and more probability to unemployment and future poverty in their futures. Reparation must consist, therefore, in providing adequate means to develop in those areas of life that have been affected. In this way, emphasis is placed on pointing out that reparation must be comprehensive and provide guarantees for the full human development of girls. On the other hand, forcing the completion of a pregnancy resulting from sexual violence against the will of the woman or adolescent can be comparable to being subjected to a situation of torture, according to international human rights standards.

The criteria to consider the evolving capacity of adolescents to make informed decisions must be observed by state agents with respect to autonomy. International human rights standards have made clear that women should be able to make informed decisions when mental health is also affected during pregnancy and women should have access to termination if this is their choice based on their health risk condition.

1. Please share examples of good practices and examples of comprehensive health responses to survivors of violence and indicate efficient multi-sectorial efforts at the community, national, regional and international levels by State or non-State actors.

The Inter-American System’s jurisprudence on reparations has evolved in recent decades. Reparation measures may include the payment of compensation, investigation, prosecution and punishment of the person responsible or measures of non-repetition that include access to health care for situations of pregnancy resulting from rape and other circumstances where legal restrictions impose mental suffering to women, girls and pregnant people. In 1994, the Inter-American Convention to prevent, punish and eradicate violence against women (hereinafter “Convention Belém do Pará” or “CBDP”) was signed, which in its Article 7º. incorporates due diligence in the framework of prevention, investigation, punishment and reparation of violence against women.

For example, recently, in the case of the 16-year-old student Paola Guzmán Albarracín, who died by suicide after suffering repeated abuse by her school´s vice principal, vs. Ecuador, the Inter-American Court of Human Rights declared state responsibility for failing its international obligations to prevent her death through timely access to health care by the public education establishment, violating her right to life and to live with dignity. The Court also found that Ecuadorian state failed in its obligation to protect adolescent from continuous sexual abuse in the educational facility and was responsible for violation of her right to live a life free from violence and her right to education.

1. Please describe State and other actors initiatives and measures to prevent these forms of violence, specific budget allocated to prevention, and good practices in this regard.

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1. For example, *ICPD beyond 2014*; CEDAW’s decisions on Communication No. 17/2008, *Alyne da Silva Pimentel Teixeira (deceased) v. Brazil* and Communication No. 22/2009, *L. C. v. Peru*; General Comments and Recommendations of CRC and CEDAW. [↑](#footnote-ref-1)
2. See e.g. *Interagency Field Manual for Reproductive Health in Humanitarian Settings* (2010): <http://www.who.int/reproductivehealth/publications/emergencies/field_manual_rh_humanitarian_settings.pdf>, and *Improving Reproductive Health: Guidelines Introduced by WHO-UNFPA Strategic Partnership Programme*: <http://www.unfpa.org/rh/guidelines.htm>. [↑](#footnote-ref-2)