

# Submission to the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health

## Inputs for the upcoming report on violence and health

Sexual Rights Initiative, January 2022

### Introduction

1. This contribution is submitted by the Sexual Rights Initiative (SRI).<sup>1</sup> The Sexual Rights Initiative is a coalition of national and regional organizations based in Canada, Poland, India, Egypt, Argentina, and South Africa that work together to advance human rights related to sexuality, and gender at the United Nations.
2. We welcome the opportunity to provide input for the upcoming report on violence and its impact on the right to health by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

**Question 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:**

- 1.1. gender based violence against women
  - 1.2. gender based violence and other forms of violence against children:
  - 1.3. gender based violence against LGBTI or other persons based on real or imputed sexual orientation, sex characteristics, and gender identity:
  - 1.4. violence against persons with disabilities, including GBV.
  - 1.5. gender based violence against men
  - 1.6. conflict gender based violence, including sexual violence
  - 1.7. Please share analysis and available evidence on the impact of COVID on the above.
3. It is important to address the ways in which gender-based violence manifests in different contexts and in which the likelihood, experience of and response to violence are shaped by interlocking systems of oppression. In a context where a lot of gender-based violence work has tended to privilege the experiences of a

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<sup>1</sup> <http://www.sexualrightsinitiative.com/å>

select set of women, often those at least partly ascribing to hegemonic norms,<sup>2</sup> there is a need to address and examine the manifestations of gender-based violence that can get missed or obscured in that context.

4. However, while it can be tempting to then examine violence “group per group” or “identity per identity,” the use of rigid identities to view, describe or respond to violence has its shortcomings.

### ***Intersectionality vs identity politics***

5. In her seminal work about intersectionality, Kimberlé Crenshaw explored the tensions between identity politics and an approach to violence that would recognize and address the multiple social locations and differences within groups:

“The problem with identity politics is not that it fails to transcend difference, as some critics charge, but rather the opposite—that it frequently conflates or ignores intragroup differences. In the context of violence against women, this elision of difference in identity politics is problematic, fundamentally because the violence that many women experience is often shaped by other dimensions of their identities, such as race and class.”<sup>3</sup>

6. If we start from and centre a narrow identity category, we run the risk of failing to address the root causes and of dividing people and movements along identities instead of uniting them across issues.
7. Indeed, “social movements utilising ‘identity’ as a driving force for recognition often operate in exclusionary ways because they fail to deconstruct institutionalised patterns and cultural values held by particular actors, and their power to reify certain identity categories. Efforts by anti-rape activists and feminism more broadly to construct a collective identity in pursuit of social justice have been heavily critiqued for failing to capture and acknowledge intersectional experiences and the ways in which institutional recognition and responses to rape disproportionately impact on men and women of colour.”<sup>4</sup>

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<sup>2</sup> Report of the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo, focusing on gender-based violence and multiple and intersecting forms of discrimination (2011) <https://undocs.org/A/HRC/17/26>, para. 42.

<sup>3</sup> Crenshaw, K. "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color". *Stanford Law Review*. 1991. 43 (6): <http://blogs.law.columbia.edu/critique1313/files/2020/02/1229039.pdf>, page 1242.

<sup>4</sup> *Online Anti-Rape Activism: Exploring the Politics of the Personal in the Age of Digital Media*, 87–119. Rachel Loney-Howes, 2020. doi:10.1108/978-1-83867-439-720201007, pages 89-90.

8. Approaches based on narrow identities and “incomplete analyses of personhood”<sup>5</sup> run the risk of privileging some experiences over others, and of creating hierarchies of violence and oppression. A hierarchy of violence – in which some individuals or groups are deemed to be more greatly or particularly harmed by acts of violence than others on the basis of their identity – necessarily creates hierarchies of ‘worthy’ and ‘innocent’ victims. This also means that other survivors and victims are treated as somehow responsible for their experiences and assumed to have suffered less harm.
  
9. Furthermore, if the presence of identities is used as evidence of the nature and extent of harm, proving and disproving identities instead of looking at the harm caused becomes the main focus of anti-violence strategies. As pointed out by Rebecca Stringer, “victimhood, under neoliberalism, has become ‘about the quality of the sufferer’ rather than the event of violence and trauma itself, constructing a hierarchy of worthy and unworthy victims, authentic and inauthentic victims of rape.”<sup>6</sup> We see the effect of this, for instance, in reduced sentences or even non-convictions for men who rape their girlfriends or wives (in the contexts in which this is even recognised as rape); thus, a focus on narrow identity categories ends up normalising violence against those who do not fit into those categories.
  
10. The Special Rapporteur on violence against women has also warned against isolating or siloing social locations when examining gender-based violence from a practical perspective, because “the norm is to use a silo approach of service delivery which addresses a narrowly defined set of issues, and operates alongside other institutions which deliver services to another narrowly defined issue.”<sup>7</sup>

***Problems with the discourse of « corrective » rape***

11. In the context of this question, presuming that lesbian, bisexual and transgender women are at “increased risk” of violence requires us to ignore the fact that violence on the grounds of sexual orientation and gender identity can only exist when all gendered people, particularly women, are constantly trained, monitored and punished to ensure they behave in ways that uphold patriarchal power structures.

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<sup>5</sup> Report of the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo, focusing on gender-based violence and multiple and intersecting forms of discrimination (2011) <https://undocs.org/A/HRC/17/26>, para. 49.

<sup>6</sup> Stringer, R. (2014). *Knowing Victims: Feminism, agency and victim politics in neoliberal times* (1st ed.). Routledge. <https://doi.org/10.4324/9781315880129>, page 41, as cited in *Online Anti-Rape Activism: Exploring the Politics of the Personal in the Age of Digital Media*, 87–119. Rachel Loney-Howes, 2020. doi:10.1108/978-1-83867-439-720201007, page 90.

<sup>7</sup> Report of the Special Rapporteur on violence against women, its causes and consequences, on multiple and intersecting forms of discrimination and violence against women, <https://undocs.org/A/HRC/17/26>, para. 42.

12. Locating the roots of all gender-based violence in patriarchal oppression and its capitalist, white supremacist and ableist counterparts resists the exceptionalisation of violence against LBT women, often incorrectly referred to as “corrective.” Indeed, such exceptionalisation contributes to categories of exceptional victims and exceptional perpetrators, propagating for instance the harmful idea that violence perpetrated by strangers is naturally worse than violence from a family member or other known person. It also obscures the fact that all rape is “corrective” as it seeks to establish and enforce the “correct” gender hierarchy and punish gender transgressions. Finally, it contributes to creating the hierarchies between victims referred to above,
  
13. In the words of the One in Nine campaign (South Africa), “[b]y assigning a unique value to some forms of violence experienced by some members of a presumably bounded community, the term [corrective rape] creates various smokescreens and untenable hierarchies—among kinds of violence and their effects, among survivors and victims of violence, and among perpetrators.”<sup>8</sup> Indeed, the implication that violence against queer women is different from or worse than sexual violence directed against heterosexual women contributes to stereotyping those categories as fixed, rigid and easily distinguishable (but needing to be proven) and to an assumption that the harms of rape experienced by heterosexual women are less “serious” in comparison.<sup>9</sup> It also contributes to popular and legal assumptions of “stranger danger” and to the undermining of marital, relationship or date rape.<sup>10</sup> Finally, it positions sexual violence as more grave and serious above all other kinds of violence, which contributes to the general lack of attention and action, also in human rights spaces, regarding the violence enacted by oppressions, structures and institutions.<sup>11</sup>
  
14. Instead, violence must be defined as the whole gamut of economic, social, psychological and political structures and norms that maintain binary gender categories and roles.

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<sup>8</sup> One in Nine Campaign: “What’s in a name? language, identity and the politics of resistance.” 2013. Introduction, page 4.

<sup>9</sup> *Ibid.*, page 4.

<sup>10</sup> *Ibid.*, page 4.

<sup>11</sup> *Ibid.*, page 4.

**Question 3: Please share examples of the types of structural and institutional violence with origins within the State, (perpetrated or condoned by the State) or perpetrated by those not representing or affiliated to the state in your country/ies of region, and who is affected. In particular, describe structural/institutional violence in medical settings against women and girls, LGBTI persons and persons with disabilities or any other individuals or groups relevant in your country/ies or regions.**

***Oppression, structural violence and human rights***

15. Patriarchal, racist, ableist and capitalist oppressions are part of the continuum of violence and of the conditions facilitating, enabling and perpetuating forms of interpersonal violence.<sup>12</sup> As noted by the Special Rapporteur on Violence against Women, “no form of interpersonal violence against women is devoid of structural violence”<sup>13</sup> and “violence against women is not the root problem, but occurs because other forms of discrimination are allowed to flourish.”<sup>14</sup>
16. Growing human rights attention to structural violence is welcome, and echoes the research and analysis on this topic in the health sector, families, education and schools developed in the decades since the term was coined in 1969 by Johan Galtung.<sup>15</sup> What Nancy Scheper-Hughes describes as the “little routines and enactments of violence” normalised in state and social institutions have a severe accumulated impact on people’s integrity and agency.<sup>16</sup> A strictly interpersonal or individual conception of violence falls short in its exclusive focus on one side of the distinction drawn by Galtung between “being killed” (direct violence) and being allowed to die (structural violence).<sup>17</sup> Yet the violence inherent in social structures of racism, ableism, patriarchy and classism and their everyday operation is evident to anyone subjected to them.
17. Using the lens of structural violence is especially important in a human rights framework and discourse that has been criticised for its frequent omission of class as a crucial health determinant, and for its emphasis on ‘underlying determinants of health’ often interpreted as more restricted in scope than the health sector’s attempt to grapple with ‘social determinants of health,’ including

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<sup>12</sup> Montesanti, S.R.; Thrurston, W.F. Mapping the role of structural and interpersonal violence in the lives of women: Implications for public health policy. *BMC Women’s Health* 2015, *15*, 100. As cited in Macassa G, McGrath C, Rashid M, Soares J. Structural Violence and Health-Related Outcomes in Europe: A Descriptive Systematic Review. *International Journal of Environmental Research and Public Health*. 2021; 18(13):6998. <https://doi.org/10.3390/ijerph18136998>, page 9.

<sup>13</sup> Report of the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo, focusing on gender-based violence and multiple and intersecting forms of discrimination (2011): <https://undocs.org/A/HRC/17/26>, para. 24

<sup>14</sup> Report of the Special Rapporteur on violence against women, its causes and consequences (2011): <https://undocs.org/A/66/215>, para. 83.

<sup>15</sup> Johan Galtung : « Violence, Peace, and Peace Research » *Journal of Peace Research* Vol. 6, No. 3 (1969), pp. 167-191.

<sup>16</sup> Hamed S, Thapar-Björkert S, Bradby H, Ahlberg BM. Racism in European Health Care: Structural Violence and Beyond. *Qualitative Health Research*. 2020;30(11):1662-1673. <https://doi.org/10.1177/1049732320931430>, page 1664.

<sup>17</sup> *Ibid.*, page 1666.

through a power and resource distribution analysis.<sup>18</sup> Going one step further than health determinants, the framing of structural violence applied to the health sector has been found to surface “the deep structural roots of health inequities; in contrast to the more passive term “social determinants of health,” structural violence explicitly identifies social, economic, and political systems as the causes of the causes of poor health. It is also evocative in its framing of health inequities as an act of violence.”<sup>19</sup>

18. Indeed, human rights discourse has not always paid enough attention to power dynamics and the necessary power analysis, despite the fact that in the context of the right to health, as correctly noted by Alicia Ely Yamin, “health is a reflection of power relations as much as biological or behavioral factors.”<sup>20</sup>
19. The use of the structural violence approach in the Global South<sup>21</sup> has been linked to a desire to visibilize and address “historical and political trauma, gender inequality, and poverty.”<sup>22</sup> In the Global North the approach has been used to describe the experiences, access to health care and health outcomes of migrants, people of color, sex workers, persons who use drugs and other people pushed to the margins, including because of class discrimination.<sup>23</sup>

### ***Violations of bodily autonomy as structural violence***

20. The fatal consequences of patriarchal structural violence are encapsulated in this statement by the Special Rapporteur on Extra-Judicial, Summary or Arbitrary Executions: “for the vast majority of women and girls, their human rights journey entails confronting a system of State actions and inactions, feeding and fed by systemic discrimination, resulting in violation of their rights to basic necessities and ultimately in a violation of their right to life.”<sup>24</sup>

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<sup>18</sup> Audrey R. Chapman: “The social determinants of health, health equity, and human rights.” *Health and Human Rights: An International Journal* 12/2 (2010):

<https://www.hhrjournal.org/2013/08/the-social-determinants-of-health-health-equity-and-human-rights/>

<sup>19</sup> De Maio F, Ansell D. “As Natural as the Air Around Us”: On the Origin and Development of the Concept of Structural Violence in Health Research. *Int J Health Serv.* 2018 Oct;48(4):749-759.

<https://pubmed.ncbi.nlm.nih.gov/30092699/>

<sup>20</sup> A. E. Yamin, “Shades of dignity: Exploring the demands of equality in applying human rights frameworks to health,” *Health and Human Rights: An International Journal* 11/2 (2009), <https://www.hhrjournal.org/2013/08/shades-of-dignity-exploring-the-demands-of-equality-in-applying-human-rights-frameworks-to-health>, as cited in <https://www.hhrjournal.org/2013/08/the-social-determinants-of-health-health-equity-and-human-rights/>

<sup>21</sup> Macassa G, McGrath C, Rashid M, Soares J. Structural Violence and Health-Related Outcomes in Europe: A Descriptive Systematic Review. *International Journal of Environmental Research and Public Health.* 2021; 18(13):6998. <https://doi.org/10.3390/ijerph18136998>, page 2.

<sup>22</sup> *Ibid.*, page 2.

<sup>23</sup> *Ibid.*, pages 2-3; 8.

<sup>24</sup> Report of the Special Rapporteur on extrajudicial, summary, or arbitrary executions on gender sensitive approach to arbitrary killings, [https://ap.ohchr.org/documents/dpage\\_e.aspx?si=A/HRC/35/23](https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/35/23), para. 90.

21. In addition to the well-documented health impacts of gender-based violence, the routine denial of bodily autonomy for women and gender-non-conforming people, constitutes a widespread and pervasive form of gender-based structural and institutional violence.<sup>25</sup> The CEDAW Committee has recognized that “[v]iolations of women’s sexual and reproductive health and rights, such as forced sterilization, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.”<sup>26</sup> Structural violence also impacts mental health: the Special Rapporteur on Health has noted that “the burden of managing and coping with systemic damage has fallen on individuals” and results in inadequate attention to structural root causes of ill health and a corresponding lack of State accountability for its obligations to respect, protect and fulfil all individuals’ right to health, including mental health.<sup>27</sup>
22. Women’s right to autonomy and self-determination over their bodies and their lives is heavily dependent on their access to available, accessible, acceptable and quality health services, including sexual and reproductive health services. However, services needed by women and anyone transgressing gender and other social norms are routinely de-prioritized and hit hardest by austerity measures and budget cuts – from abortion to contraception, harm reduction programmes, shelters, disability benefits, etc.
23. Bodily autonomy and structural violence must be addressed from an intersectional perspective that goes beyond the health sector or individualistic conceptions of informed consent to examine the systems of oppression and material conditions shaping the exercise or denial of that autonomy. An absence or insufficiency of these material conditions must be considered as a form of structural violence, and provides the conditions enabling all kinds of violence - from the institutional to the interpersonal level.
24. While the examples are too many to list, some egregious illustrations of structural violence in health care and its intersectional dimensions include

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<sup>25</sup> As noted by the former Special Rapporteur on Violence against Women Rashida Manjoo, “[w]omen’s right to self-determination includes the ability to determine their political status and freely pursue their economic, social and cultural development. Any group or persons that infringe this right are perpetuating a form of structural violence against the disempowered group, and further marginalizing the rights of certain women within a given political context.” (<https://undocs.org/en/A/HRC/17/26>, para. 97)

<sup>26</sup> Committee on the Elimination of Discrimination against Women: General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 1 (2017), para. 18.

<sup>27</sup> Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/41/34, 2019: <https://undocs.org/A/HRC/41/34>, para. 7.

preventable maternal mortality and morbidity (see also question 4)<sup>28</sup> including maternal mental ill-health, where pregnancy compounds the pre-existing and intersecting forms of injustice experienced;<sup>29</sup> as well as State-sanctioned forced sterilization policies across the world targeting women and persons who are marginalized and subject to intersecting forms of discrimination on the basis of their HIV status, race, class, gender identity, sex characteristics, immigration status or disability. This violent form of social control is rooted in eugenics and patriarchal, racist, ableist, colonial and capitalist systems of oppression determining whose bodily autonomy and integrity are expendable.<sup>30</sup>

25. For women with disabilities, structural violence and violations of bodily autonomy in health care can also take the form of denial of legal capacity and informed consent, restriction of access to health and social protection on the basis of standards and regulations based on notions of “productivity” and “dependency,”<sup>31</sup> and the enduring prevalence of biomedical rather than human-rights based approaches to disability, treating medical staff as experts with authority over their lives.<sup>32</sup>
26. Research into racism in health care in several European countries has found that the frame of structural violence allows surfacing the processes through which racism is enacted and reproduced in health care settings, in a European context in which race is silenced in law and policy and treated as “an individual aberration

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<sup>28</sup> OHCHR has linked intersectional discrimination “a heightened inability to access adequate health-care systems and timely interventions and services, although the reasons for this inability may differ. For example, laws or social practices often place age limits, or restrictions related to marital status, on access to sexual and reproductive health care, services and information. Meanwhile for reasons of distance, cost and lack of information women living in rural areas, indigenous women, displaced persons/refugees, girls, or women of lower social and economic status may not have sufficient access to antenatal services, emergency obstetric care and skilled birth attendants.” United Nations Office of the High Commissioner for Human Rights, Preventable Maternal Mortality and Morbidity and Human Rights, para 20

<https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportMaternalMortality.pdf>

On this topic, please see the SRI submission to the Office of the High Commissioner on Human Rights for its report on maternal mortality and morbidity (2020).

<sup>29</sup> Risk factors for maternal mental health include mostly socially determined elements - and forms of violence - such as poverty, migration, extreme stress, exposure to violence (domestic, sexual and gender-based), emergency and conflict situations, natural disasters, and low social support generally.

(See PMNCH: Maternal Mental health: Why it Matters and What countries

With limited resources can do:

<https://www.who.int/pmnch/knowledge/publications/summaries/ks31.pdf>)

<sup>30</sup> Sexual Rights Initiative, Her Rights Initiative and Women’s Legal Centre: Online side event on forced sterilization held during the 47th session of the Human Rights Council, on 25 June 2021.

On this topic, see also the Commission for Gender Equality (South Africa)’s investigative report on the forced sterilisation of women living with HIV/AIDS in South Africa: Complaint Ref No: 414/03/2015/KZN, available at <http://srjc.org.za/wp-content/uploads/2020/03/Forced-Sterilisation-Report.pdf>

<sup>31</sup> On this topic, please see the SRI submission to the CRPD Committee on its concept note on art. 27 (right to work): [https://www.sexualrightsinitiative.com/sites/default/files/resources/files/2021-](https://www.sexualrightsinitiative.com/sites/default/files/resources/files/2021-07/Sexual%20Rights%20Initiative%20-%20Submission%20to%20CRPD%20for%20General%20Comment%20on%20art27.pdf)

[07/Sexual%20Rights%20Initiative%20-%20Submission%20to%20CRPD%20for%20General%20Comment%20on%20art27.pdf](https://www.sexualrightsinitiative.com/sites/default/files/resources/files/2021-07/Sexual%20Rights%20Initiative%20-%20Submission%20to%20CRPD%20for%20General%20Comment%20on%20art27.pdf)

<sup>32</sup> On bioethics and the rights of persons disabilities, please see the SRI submission to the Special Rapporteur on the rights of persons with disabilities:

<https://www.sexualrightsinitiative.com/fr/node/733>



[...] and not a structural societal issue” based on the fallacy of a “post-racist” society.<sup>33</sup> In this sense, approaching racism as structural violence is “a way to understand the conundrum of racism, its invisibility, and obfuscation, on one hand, and its material consequences that shape the risk of morbidity and mortality, on the other.”<sup>34</sup> Indeed, the manifestations of racism in health care are far-reaching and severe, ranging from generally poorer mental and physical health outcomes, delayed provision of adequate health care, lower likelihood of receiving kidney transplants, inadequate pain management arising from racialized patients’ pain not being taken seriously, denial of their agency in decision-making, or de-prioritization of care under the pretext of limited resources.<sup>35</sup>

27. This analysis of European racist structural violence in health care at the national level is echoed at the international level, where populations in the Global South are constantly confronted with barriers to access vaccines, medicines and treatments. From HIV treatment<sup>36</sup> to COVID-19<sup>37</sup> and HPV vaccines,<sup>38</sup> to cite only a few, intellectual property regimes and pharmaceutical monopolies continue to privilege profits – and therefore wealthy nations and individuals – over universal health coverage. Civil society has called attention to the racism inherent in this situation: “Because the rich countries currently making and hoarding vaccines are majority white, and the formerly colonized countries suffering due to vaccines being withheld are majority Black, indigenous, or other people of colour, the current inequitable vaccine rollout is a textbook example of structural racial discrimination.”<sup>39</sup> In addition, these obstructions to vaccine access extend the duration of a pandemic that itself continues to aggravate economic, gender and racial inequalities.<sup>40</sup>

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<sup>33</sup> Hamed S, Thapar-Björkert S, Bradby H, Ahlberg BM. Racism in European Health Care: Structural Violence and Beyond. *Qualitative Health Research*. 2020;30(11):1662-1673.  
<https://doi.org/10.1177/1049732320931430>, pages 1662-3.

<sup>34</sup> *Ibid.*, page 1663.

<sup>35</sup> *Ibid.*, page 1663.

<sup>36</sup> MSF statement concerning intellectual property and access to medicines in the 2021 UN High-Level Meeting on HIV/AIDS Declaration (June 2021):  
<https://msfaccess.org/msf-statement-concerning-intellectual-property-and-access-medicines-2021-un-high-level-meeting>

<sup>37</sup> See the work and demands of the People’s Vaccine Alliance: <https://peoplesvaccine.org/our-demands/>

<sup>38</sup> Subhashini Chandrasekharan, Tahir Amin, Joyce Kim, Eliane Furrer, Anna-Carin Matterson, Nina Schwalbe, Aurélia Nguyen: “Intellectual property rights and challenges for development of affordable human papillomavirus, rotavirus and pneumococcal vaccines: Patent landscaping and perspectives of developing country vaccine manufacturers.” *Vaccine*, Volume 33, Issue 46, 2015, Pages 6366-6370,  
<https://doi.org/10.1016/j.vaccine.2015.08.063>.

<sup>39</sup> Urgent action appeal sent to the UN Committee on the Elimination of Racial Discrimination by an international coalition of human rights law groups, public health experts, and civil society organisations:  
<https://movementlawlab.org/covid-healthcare-equity>

<sup>40</sup> Nabil Ahmed: “Inequality Kills: The unparalleled action needed to combat unprecedented inequality in the wake of COVID-19.” Oxfam International, January 2022.  
<https://oxfamlibrary.openrepository.com/bitstream/handle/10546/621341/bp-inequality-kills-170122-en.pdf;jsessionid=0357E79A4E1055BF74247BF3657969CE?sequence=9>, page 29.

**Question 4: 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.**

***Sex work***

28. As sex workers movements have long advocated, and as reaffirmed by several Special Procedures mandates, laws criminalizing sex work are inherently discriminatory,<sup>41</sup> compound sex workers' social exclusion and economic marginalization,<sup>42</sup> and infringe on a range of human rights, including the rights to health, non-discrimination and freedom from gender-based violence. Criminalization exposes sex workers to abuse, structural and interpersonal violence, and causes and aggravates stigma associated with sex work, particularly as it relates to seeking assistance and reporting violence to health workers, police, and state social services.
29. During the pandemic, the criminalization of sex work in many countries has meant that sex workers are excluded from emergency social protection measures and government support and face very precarious situations.<sup>43</sup> Despite the fact that sex work often requires close proximity and contact with clients, sex workers in Eswatini have struggled to access personal protective equipment such as masks, in addition to facing reduced access to condoms and HIV treatment.<sup>44</sup> The pandemic and related curfew and confinement measures have also impacted sex workers' livelihoods, in a context in which they are often excluded from government support and relief programs.<sup>45</sup> In Tanzania, stereotypes about sex workers lead to them being blamed for spreading HIV and COVID-19.<sup>46</sup> In

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<sup>41</sup> See *e.g.* Report of the Special Rapporteur on the right of everyone to the highest attainable standard of health on criminalization of same-sex conduct and sexual orientation, sex-work and HIV transmission (2010), A/HRC/14/20, para. 6; Report of the Working Group on the issue of discrimination against women in law and in practice, A/HRC/38/46 (2018), para. 32.

<sup>42</sup> NSWP Briefing Note on Social Protection (2019), available at [https://www.nswp.org/sites/nswp.org/files/briefing\\_note\\_social\\_protection\\_nswp\\_-\\_2019\\_0.pdf](https://www.nswp.org/sites/nswp.org/files/briefing_note_social_protection_nswp_-_2019_0.pdf), pages 2-3.

<sup>43</sup> See for instance the NSWP submission in response to the joint questionnaire by Special Procedure mandate holders on protecting human rights during and after the COVID-19 pandemic, 2020, available at <https://ohchr.org/Documents/HRBodies/SP/COVID/NGOs/NSWP.docx>, and the UNAIDS and NSWP joint press statement "Sex workers must not be left behind in the response to COVID-19" at [https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/april/20200408\\_sex-workers-covid-19](https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/april/20200408_sex-workers-covid-19)

<sup>44</sup> Joint stakeholder submission by the African Sex Workers Alliance (ASWA) and the Sexual Rights Initiative for the Universal Periodic Review of Eswatini, <https://sexualrightsinitiative.com/sites/default/files/resources/files/2021-05/UPR%2039%20Eswatini%20ASWA%20and%20SRI.pdf>, para. 26.

<sup>45</sup> *Ibid.*, para. 27.

<sup>46</sup> Joint stakeholder submission by an anonymous human rights defender from Tanzania, the Southern Africa Litigation Centre, and the Sexual Rights Initiative for the Universal Periodic Review of Tanzania, <https://sexualrightsinitiative.com/sites/default/files/resources/files/2021-05/UPR%2039%20Tanzania%20SALC%20and%20SRI%20%20.pdf>, para. 19.

Denmark, the inability to access proper workspaces, COVID-19 lockdown measures and a legal framework criminalizing aspects of sex work have increased the precarity of sex workers, exacerbating a context in which abusive clients can act with impunity.<sup>47</sup>

30. In Canada, despite the Supreme Court striking criminal code provisions that undermined sex workers' health and safety in 2013, sex workers continue to be criminalised.<sup>48</sup> The negative consequences associated with the ongoing criminalization of sex work include:

- Displaced and isolated sex workers who fear and avoid contact with police and other law enforcement which increases targeted violence against sex workers
- Interference with safety mechanisms that sex workers use to stay safe<sup>49</sup>
- Fear among sex workers of legal consequences or harassment if they carry condoms and lubricant, which can be used as evidence of sex work<sup>50</sup>
- The reduction of sex workers' ability to negotiate safer sex with clients (on the street as well as indoors or on the phone)<sup>51</sup>
- A negative impact on relationships between sex workers and any service providers (such as those providing condoms and harm reduction

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<sup>47</sup> Joint stakeholder submission by That's What She Said and the Sexual Rights Initiative for the Universal Periodic Review of Denmark, <https://sexualrightsinitiative.com/sites/default/files/resources/files/2020-12/UPR%2038%20Denmark%20TWSS%20and%20SRI.pdf>, para. 7.

<sup>48</sup> The current legislation, the Protection of Communities and Exploited Persons Act (PCEPA), enacted following the Supreme Court ruling, effectively re-criminalized sex work and continues to violate the human rights of sex workers. Specifically, the legislation criminalises the purchase of sexual services; communicating for the purpose of purchasing and selling sexual services; receiving a material benefit from the crimes of purchasing sexual services or communicating to obtain them; procuring a person to offer or provide sexual services for consideration; and prohibiting advertising of sexual services.

<sup>49</sup> Canadian Alliance for Sex Work Law reform: "Safety, Dignity, Equality: Recommendations for Sex Work Law Reform in Canada" <http://sexworklawreform.com/wp-content/uploads/2017/05/CASWLR-Final-Report-1.6MB.pdf>

<sup>50</sup> Canadian Alliance for Sex Work Law Reform: factsheet "Why Decriminalization is Consistent with Public Health Goals." <https://drive.google.com/folderview?id=0B3mqMOhRg5FeLWpPd21VYtIidTA&usp=sharing&tid=0B3mqMOhRg5FeNIY4ZkxGb2pLaWM>

<sup>51</sup> Kim Blankenship and Stephen Koester, "Criminal Law, Policing Policy and HIV Risk in Female Street Sex Workers and Injection Drug Users" (2002) 30 Journal of Law, Medicine and Ethics 548, p.550; Annika Eriksson and Anna Gavanas, Prostitution in Sweden 2007 (Socialstyrelsen 2008) [http://www.socialstyrelsen.se/lists/artikelkatalog/attachments/8806/2008-126-65\\_200812665.pdf](http://www.socialstyrelsen.se/lists/artikelkatalog/attachments/8806/2008-126-65_200812665.pdf) p.48; Ulf Stridbeck (ed.), Purchasing Sexual Services in Sweden and the Netherlands: Legal Regulation and Experiences—An Abbreviated English Version. A Report by a Working Group on the legal regulation of the purchase of sexual services (Justis-og Politidepartementet, 2004) [http://www.regjeringen.no/upload/kilde/jd/rap/2004/0034/ddd/pdfv/232216-purchasing\\_sexual\\_services\\_in\\_sweden\\_and\\_the\\_netherlands.pdf](http://www.regjeringen.no/upload/kilde/jd/rap/2004/0034/ddd/pdfv/232216-purchasing_sexual_services_in_sweden_and_the_netherlands.pdf) pages 13 and 19; Petra Östergren, "Sexworkers critique of Swedish Prostitution policy" (2004), [http://www.petraostergren.com/pages.aspx?r\\_id=40716](http://www.petraostergren.com/pages.aspx?r_id=40716); Rosie Campbell and Merl Storr, "Challenging the Kerb Crawler Rehabilitation Programme" (2001) 67 Feminist Review 94, 102 citing Steph Wilcock, The Lifeline Sexwork Project Report: Occupational Health and Safety Issues and Drug Using Patterns of Current Sexworker: Survey Findings (Manchester: Lifeline, 1998); Pro Sentret, Året 2010/2011), pages 72, 78-79.

supplies) as sex workers may fear being identified as sex workers, which could lead to police entrapment<sup>52</sup>

- Heightened risks of HIV and other sexually transmitted infections as sex workers face substantial barriers in accessing prevention, treatment, and care services<sup>53</sup>

31. In Canada and across the world, this type of legislation forces sex workers into unsafe and unprotected areas, and restricts access to important safety strategies that can have significant and profound negative consequences on sex workers' health, security, safety, equality, and human rights.

32. This is especially alarming for people in precarious immigration situations. Canada's sex work-related laws do not explicitly address migrant sex workers, but their stated objective is to "ensure consistency between prostitution offences and the existing human trafficking offences."<sup>54</sup> This means that human trafficking frameworks are being used to understand sex work.<sup>55</sup> In Canada and many other countries, because migrant sex workers are often identified as "trafficked victims" and because their work is often referred to as "sexual exploitation," laws and policies criminalizing both sex work and migration lead to racialized sex workers being specifically targeted.<sup>56</sup>

### **Abortion**

33. Unsafe abortion is one of the leading causes of maternal mortality.<sup>57</sup> While similar assumptions could be made about the impacts of unsafe abortion on maternal morbidity for those who survive, this remains an assumption due to scarcity of data. Further, the restriction and stigmatisation of abortion services across the world discourages women from coming forward with information

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<sup>52</sup> Helseidrettoratet (Norwegian Directorate of Health), UNGASS Country Progress Report Norway: Jan. 2008–Dec. 2009 (Helseidrettoratet, Apr. 2010)  
[http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/norway\\_2010](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/norway_2010).

<sup>53</sup> Criminalisation of clients: reproducing vulnerabilities for violence and poor health among street-based sex workers in Canada—a qualitative study <https://bmjopen.bmj.com/content/4/6/e005191>

<sup>54</sup> [https://laws-lois.justice.gc.ca/eng/annualstatutes/2014\\_25/page-1.html](https://laws-lois.justice.gc.ca/eng/annualstatutes/2014_25/page-1.html)

<sup>55</sup> For more on the harmful conflation of sex work and trafficking, please see the SRI submission to the CEDAW Committee for its General Recommendation 35 on Trafficking, available at <https://www.ohchr.org/Documents/HRBodies/CEDAW/GRTrafficking/SexualRightsInitiative.docx> and the joint submission by the Global Network of Sex Work Projects (NSWP) and the SRI to the Working Group on Discrimination Against Women and Girls for their report on deprivation of liberty: <https://www.sexualrightsinitiative.com/resources/sri-submission-working-group-discrimination-against-women-and-girls-deprivation-liberty>

<sup>56</sup> Canadian Alliance of Sex Work Law Reform. [www.sexworklawreform.com](http://www.sexworklawreform.com) and Supporting Women's Alternatives Network (SWAN Vancouver). 2015. "Chinese Sex Workers in Toronto and Vancouver." <http://swanvancouver.ca/wp-content/uploads/2015/05/Chinese-sex-workers-in-Toronto-amp-Vancouver-Ziteng-SWAN-amp-ACSA.pdf>

<sup>57</sup> World Health Organisation, <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>

regarding the abortion or possible impact.<sup>58</sup> Research on abortion-related morbidity in settings with limited access to abortion services has highlighted that “defining and accurately measuring abortion-related morbidity is important for understanding the spectrum of risk associated with unsafe abortion and for assessing the impact of changes in abortion-related policy and practices.”<sup>59</sup> And yet, statistics on maternal morbidity due to unsafe abortion are rare and often rely on estimates that are not without limitations.<sup>60</sup> Singh and Maddow-Zimet estimated that in 2012, 7 millions of women in the Global South were treated for complications arising from unsafe termination of pregnancy after reaching health facilities, based on data from 26 countries.<sup>61</sup>

34. Available evidence does find that the prevalence of least-safe abortions increases with increased restrictions on access to safe abortions and that the proportion of least-safe abortions increases from 1% in high-income countries to 5% in upper-middle-income countries, 20% in lower-middle-income countries and 54% in low-income countries<sup>62</sup> This places a higher burden on health systems in countries that can least afford it, for entirely non-medical reasons.<sup>63</sup>
35. States have an obligation, even in restricted legal settings, to ensure access to post-abortion care.<sup>64</sup> However, in countries with severe restrictions on abortion, many women who experience complications from unsafe abortion put off seeking care until their symptoms become life threatening.<sup>65</sup> This is starkly illustrated in countries such as El Salvador where women are incarcerated for seeking out abortion services resulting in a chilling effect for women and health

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<sup>58</sup> SRI submission to the Office of the High Commissioner on Human Rights for its report on maternal mortality and morbidity (2020).

<sup>59</sup> Calvert C, Owolabi OO, Yeung F, et al. The magnitude and severity of abortion-related morbidity in settings with limited access to abortion services: a systematic review and meta-regression. *BMJ Glob Health* 2018;3:e000692. doi:10.1136/bmjgh-2017-000692, page 1.

<sup>60</sup> See e.g. the WHO’s estimate in its evidence brief on preventing unsafe abortion, which states that “[u]nsafe abortions lead to an estimated 7 million complications” (<https://apps.who.int/iris/bitstream/handle/10665/329887/WHO-RHR-19.21-eng.pdf?ua=1>), based on estimates which its authors acknowledge have several significant limitations. (Singh S, Maddow-Zimet I. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. *BJOG* 2016;123: page 1494).

<sup>61</sup> Singh S, Maddow-Zimet I. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. *BJOG* 2016;123:1489–1498.

<sup>62</sup> Ganatra B et al., Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, *Lancet*, 2017, [http://dx.doi.org/10.1016/S0140-6736\(17\)31794-4](http://dx.doi.org/10.1016/S0140-6736(17)31794-4).

<sup>63</sup> SRI submission to the Office of the High Commissioner on Human Rights for its report on maternal mortality and morbidity (2020).

<sup>64</sup> This has been recognized through the treaty bodies as well as intergovernmental negotiated agreements including the ICPD Programme of Action and the Beijing Platform for Action.

<sup>65</sup> Singh S., Remez, L., Sedgh, G., Kwok, L., and Onda, T. *Abortion Worldwide 2017: Uneven Progress and Unequal Access*. Guttmacher Institute, 2018.

providers,<sup>66</sup> or in Poland where the 2020 Constitutional Tribunal Ruling introduced a near-total ban on abortion with deadly consequences.<sup>67</sup>

36. Removing legal and other restrictions to safe abortion and expanding access to this critical health service is at the heart of a human rights based approach to preventable maternal mortality and morbidity, among other aspects of bodily autonomy, precisely because it addresses the social, cultural and legal conditions that contribute to *preventable* violations of women's and girls sexual and reproductive rights.<sup>68</sup>

**Question 5: 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.**

37. Responses to gender-based violence are too often focused on protectionist and carceral approaches, or approaches that rely on criminalisation, punishment and incarceration. In addition to failing to stem violence, carceral approaches to gender-based violence only result in the further marginalisation of poor and socially disenfranchised men in various societies.<sup>69</sup>

38. Protectionist approaches tend to treating women and girls not as autonomous but as “vulnerable” and in need of protection - from themselves and/or from real and perceived dangers<sup>70</sup> - and reducing their identity to their sexual and reproductive capacities in the face of sexual violence it views as inevitable, at the national and international level.<sup>71</sup>

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<sup>66</sup> Committee on the Elimination of Discrimination against Women: Concluding observations on the combined eighth and ninth periodic reports of El Salvador, CEDAW/C/SLV/CO/8-9 (2017): <https://undocs.org/CEDAW/C/SLV/CO/8-9>, para 36-37.

<sup>67</sup> Federation for Women and Family Planning: Death toll of anti-abortion law in Poland (November 2021): <https://en.federa.org.pl/death-toll-of-antiabortion-law-in-poland/>  
See also Federa's submission to the Special Rapporteur on the Right to Health, focusing on the right to sexual and reproductive health during the COVID-19 pandemic: <https://www.ohchr.org/Documents/Issues/Health/sexual-reproductive-health-covid/CSOs/ngo.federa.pdf>

<sup>68</sup> SRI submission to the Office of the High Commissioner on Human Rights for its report on maternal mortality and morbidity (2020).

<sup>69</sup> On this topic, please see [the joint submission by SRI, NSWP, and IWRAW Asia Pacific](#) to the Special Rapporteur on violence against women for her report on rape, as well as the SRI's [submission](#) on the 25 years of the mandate of the Special Rapporteur on Violence against Women.

<sup>70</sup> An example of this is the practice of “rescuing” and “rehabilitating” sex workers, with no regard for the wishes, desires or decisions of the sex workers themselves. See, for instance, the joint submission by SRI and NSWP to the Working Group on Discrimination against Women and Girls for its report on women deprived of liberty: <https://www.sexualrightsinitiative.com/resources/sri-submission-working-group-discrimination-against-women-and-girls-deprivation-liberty>

<sup>71</sup> See SRI: “A review of key trends in relation to SRHR in Geneva-based human rights spaces in 2020.” <https://www.sexualrightsinitiative.com/resources/review-key-trends-relation-srhr-geneva-based-human-rights-spaces-2020>

39. As outlined in a joint submission by SRI, NSWP and IWRAW Asia-Pacific to the Special Rapporteur on violence against women,<sup>72</sup> these approaches are often associated with an exclusive focus on interpersonal violence and an individualistic perspective- either that of the person who has been subjected to violence or the person perpetrating violence. The criminal justice response to GBV has its roots in this paradigm, that often ignores the ways in which systems and structures perpetuate, contribute to and are complicit in gender-based violence and the resulting inadequacy of responses anchored in this approach. The widespread prevalence of this individualistic perspective has often resulted in feminist and social justice movements moving away from addressing the material conditions and structural oppressions and towards creating more categories of crimes, higher punishment and increased incarceration of marginalised groups based on race and class locations.<sup>73</sup> The Special Rapporteur on Violence against Women has addressed this individualistic approach and recommended that States undertake “systemic due diligence” in responding to GBV, which includes transformative change.<sup>74</sup>
40. The drive to utilise criminal law, increase criminal legislations and increase punishment is neither new nor obscure.<sup>75</sup> It is rooted in the assertion of power and control and a renewed commitment to the neoliberal notion of the ‘safe’ and ‘clean’ family conceptualised in contrast to an environment of fear and paranoia. This commitment to law and order is coupled with a commitment to “family values.” The result is that the private family is the institution that should be supported and furthered, and people are governed through crime and/or law and order.<sup>76</sup> This combination of protecting the private family and using criminal law to control deviations from the norm is a necessary condition for the neoliberal state apparatus. As has been established repeatedly that the “neoliberal economic strategies redirect public monies away from the provision of goods and services, they in fact require an enhanced penal apparatus to contain newly disenfranchised populations.”<sup>77</sup>
41. Liberal feminist groups have often called criminal law as the ‘law which protects’, downplaying the fact that the criminal law is also ‘law from which protection is required.’ The rise of neoliberalism, and the shrinking welfare state, have also

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<sup>72</sup> Joint submission by SRI, NSWP, and IWRAW Asia Pacific to the Special Rapporteur on violence against women for her report on rape, December 2020: <https://www.sexualrightsinitiative.com/resources/joint-submission-special-rapporteur-violence-against-women-its-causes-and-consequence>

<sup>73</sup> *Ibid.*, para. 4.

<sup>74</sup> Report of the Special Rapporteur on violence against women, its causes and consequences, A/HRC/23/49, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G13/136/39/PDF/G1313639.pdf?OpenElement>, para. 70.

<sup>75</sup> Karen Engle, Anti-Impunity and the Turn to Criminal Law in Human Rights, 100 Cornell L. Rev. 1069 (2015) Available at: <http://scholarship.law.cornell.edu/clr/vol100/iss5/2>

<sup>76</sup> Bernstein, Elizabeth. "Carceral Politics as Gender Justice? The "traffic in Women" and Neoliberal Circuits of Crime, Sex, and Rights." *Theory and Society* 41, no. 3 (2012): 233-59. <http://www.jstor.org/stable/4147571>, page 259.

<sup>77</sup> *Ibid.*, pages 237-3.

reinforced women's rights groups' reliance on the punitive aspect of state power, as opposed to other non-punitive policies of economic protection and redistributive justice. Among other consequences is a tendency toward state overreach as part of this emphasis on the state's retributive and punitive power.<sup>78</sup> However, there are theories that the rise of this feminist approach is very intrinsically linked to the decline of the welfare state, and the rise of the neoliberal state and economic order. This approach made "marriage" the primary institution that needs to be preserved and "the family" as an institution that is under threat and needs to be secure, creating a racialized and classed hierarchy.<sup>79</sup> Law and order, policing, security apparatus came to be the primary vehicle for this state.<sup>80</sup> The primacy of law and order affects the meaning and practice of sexual politics within this paradigm, preserving the "private sphere", giving credence to moral panics on sexuality and gender. As highlighted, "this new paradigm has been disseminated through such disparate means as stepped up laws and controls against sex offenders (including proposals for a pan-European sex offender registry), the insertion of men into private-sphere caring labour via official World Bank development policy, and burgeoning international campaigns against the traffic in women."<sup>81</sup>

42. It is imperative the Special Rapporteur challenge rather than reinforce these problematic conceptual underpinnings of responses to sexual violence. Less than 4% of women who experience violence report it,<sup>82</sup> the mass movements against sexual violence like #MeToo, #NiUnaMenos #TotalShutDown point to a systems failure when it comes to using a carceral approach to gender-based violence. This over-reliance and lack of critical perspective on the criminal law approach is not restricted to some areas, it has seeped into regional and international human rights systems. Human rights bodies progressively appear to view criminal law as a fundamental "justice mechanism" that safeguards society as a whole by ending impunity and providing general human rights protection.<sup>83</sup> This, despite the fact that justice is too frequently not served by criminal laws, on the contrary law administration machineries are often the repressive, coercive arm of the state. For instance, gender-based violence by the

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<sup>78</sup> Alice M. Miller, Sexuality, violence against women, and human rights: Women make demands and ladies get protection. *Health and Human Rights*, 7(2), 17-47 (2004).

<sup>79</sup> Bernstein, Elizabeth. "Carceral Politics as Gender Justice? The "traffic in Women" and Neoliberal Circuits of Crime, Sex, and Rights." page 251.

<sup>80</sup> Hadar Aviram, Progressive Punitivism: Notes on the Use of Punitive Social Control to Advance Social Justice Ends, 68 *Buff. L. Rev.* 199 (2020). Available at:

<https://digitalcommons.law.buffalo.edu/buffalolawreview/vol68/iss1/4>

<sup>81</sup> Bernstein, Elizabeth. "Carceral Politics as Gender Justice? The "traffic in Women" and Neoliberal Circuits of Crime, Sex, and Rights." page 251.

<sup>82</sup> See <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

<sup>83</sup> Mattia Pinto, Historical Trend of Human Rights Gone Criminal LSE Law, Society and Economy Working Papers 4/2020, [www.lse.ac.uk/collections/law/wps/wps.htm](http://www.lse.ac.uk/collections/law/wps/wps.htm) and the Social Sciences Research, Network electronic library at: <https://ssrn.com/abstract=3561635>

The discussions during the Human Rights Council's urgent debate on current racially inspired human rights violations, systemic racism, police brutality and violence against peaceful protests, illustrates some of this point as well.



military State is sanctioned and protected in occupied territories like Kashmir.<sup>84</sup> The colonial underpinnings of criminal justice systems ensure that these systems are ways to target and monitor the oppressed and the non-conforming. Consequently, they are often used to criminalize and monitor activities that do not fit in these paradigms, including but not limited to sex work and migration. In some situations, international law itself provides the impetus for criminalization of sex workers, especially migrant sex workers, under the misguided and protectionist framework that conflates sex work and trafficking.<sup>85</sup>

**Question 6: Please specify the budget allocated in your country/ies in focus, to health-related response to survivors of all/some forms of violence mentioned above. Please indicate the percentage of the national budget devoted to this; the percentage of the international aid provided or received for this. Please explain the impact of Covid 19 to the funding of responses to all/some forms of violence in your State/institution.**

### *Economic violence and the world order*

43. As highlighted by the Independent Expert on Foreign Debt, “the current economic system is, for the most part, sustained by gender inequality and discrimination against women.”<sup>86</sup> Macroeconomic policies and mainstream economics are often male-biased and androcentric, leading to the imposition of structural adjustment and fiscal consolidation policies without due regard for their negative human rights or gendered impacts – or for the expertise and recommendations of feminist economists and women’s rights advocates.<sup>87</sup>
44. As Oxfam puts it, “economic violence is perpetrated when structural policy choices are made for the richest and most powerful people. This causes direct harm to us all, and to the poorest people, women and girls, and racialized groups most.”<sup>88</sup> If we are to believe the reports that the COVID-19 pandemic has been both a period of incredible fortune growth for billionaires<sup>89</sup> and a time of worsening economic, racial and gender inequalities for the overwhelming

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<sup>84</sup> See <https://countercurrents.org/2019/08/kashmir-caged-fact-finding-report/> and <https://blogs.lse.ac.uk/gender/2019/09/09/militarisation-kashmir/>

<sup>85</sup> NSWP: “The Impact of Anti-trafficking legislation and Initiatives on Sex Workers.” (2019) <https://www.nswp.org/resource/nswp-policy-briefs/policy-brief-the-impact-anti-trafficking-legislation-and-initiatives-sex>

<sup>86</sup> Report of the Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, particularly economic, social and cultural rights: Impact of economic reforms and austerity measures on women’s human rights, A/73/179, 2018, <http://www.undocs.org/A/73/179>, para. 78.

<sup>87</sup> *Ibid.*, paras. 7, 10, 89.

<sup>88</sup> Nabil Ahmed: “Inequality Kills: The unparalleled action needed to combat unprecedented inequality in the wake of COVID-19.” Oxfam International, January 2022. <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621341/bp-inequality-kills-170122-en.pdf;jsessionid=0357E79A4E1055BF74247BF3657969CE?sequence=9>, page 2.

<sup>89</sup> *Ibid.*, page 10.

majority of the world's population, economic violence shows no signs of abating unless radical measures are taken.

### ***Neoliberalism and health funding***

45. Around the world, health systems and health financing have been eroded, undermined and weakened by decades of neoliberalism, austerity, privatisation and structural adjustment programs and an emphasis on minimising State intervention and relying on a discourse of “personal responsibility.”<sup>90</sup> The negative human rights impacts of these policies, the prevalence of market forces over human rights and the lack of accountability in that context have been criticised by several Special Procedures mandates and treaty bodies.<sup>91</sup>
46. This has been especially destructive in countries across the Global South, where the concept of structural violence has been used to describe the effects of neoliberalism, austerity and structural adjustment programmes, combined and compounded with the enduring impacts of colonial dispossession and domination.<sup>92</sup> In the European Union too, “neoliberal policies [...] have resulted in damaging budget cuts and created pressures to privatise and commercialise healthcare and elderly care systems, thereby weakening Europe’s pandemic preparedness.”<sup>93</sup> Neoliberal approaches to health spending have disproportionate impacts along gender, race and class lines and are themselves a form of structural and economic violence that needs to be addressed to ensure that health systems are robust and equipped to stop reproducing and enacting structural violence onto the most marginalised, and to respond to survivors of interpersonal violence.

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<sup>90</sup> Macassa G, McGrath C, Rashid M, Soares J. Structural Violence and Health-Related Outcomes in Europe: A Descriptive Systematic Review. *International Journal of Environmental Research and Public Health*. 2021; 18(13):6998. <https://doi.org/10.3390/ijerph18136998>, page 10.

<sup>91</sup> See e.g. the Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context on financialization of housing and the right to adequate housing, A/HRC/34/51, 2017, <https://undocs.org/A/HRC/34/51>; Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context, Raquel Rolnik, A/HRC/10/7, 2009, <https://undocs.org/A/HRC/10/7>; Report of the Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, particularly economic, social and cultural rights: Responsibility for complicity of international financial institutions in human rights violations in the context of retrogressive economic reforms, A/74/178, 2019, <http://www.undocs.org/A/74/178>, para. 36; Statement by the Committee on Economic, Social and Cultural Rights: Public debt, austerity measures and the International Covenant on Economic, Social and Cultural Rights, E/C.12/2016/1, 2016, <https://undocs.org/en/E/C.12/2016/1>

<sup>92</sup> Macassa G, McGrath C, Rashid M, Soares J. Structural Violence and Health-Related Outcomes in Europe: A Descriptive Systematic Review. *International Journal of Environmental Research and Public Health*. 2021; 18(13):6998. <https://doi.org/10.3390/ijerph18136998>, page 10.

<sup>93</sup> Corporate Europe Observatory: “When the market becomes deadly: How pressures towards privatisation of health and long-term care put Europe on a poor footing for a pandemic.” January 2021. <https://corporateeurope.org/sites/default/files/2021-01/healthcare-privatisation-final.pdf>, page 23.

47. The mandate of the Special Rapporteur on the right to health has long warned that:

“the global trend towards privatisation in health systems poses significant risks to the equitable availability and accessibility of health facilities, goods and services, especially for the poor and other vulnerable or marginalised groups. In many cases, privatisation has led to increased out-of-pocket payments for health goods and services, disproportionate investment in secondary and tertiary care sectors at the expense of primary health care, and increased disparity in the availability of health facilities, goods and services among rural, remote and urban areas.”<sup>94</sup>

48. This privatisation is fuelled and exacerbated by persistent deficits, unavailability of public funds in absolute terms and low prioritisation of health by governments in their public expenditure.<sup>95</sup> None of these factors work alone; they feed into each other resulting in making health systems inaccessible for the people who most need them.<sup>96</sup> The violent impacts of neoliberal approaches to health are translated in numbers: recent Oxfam research estimates that for 5.6 million people per year in poor countries, lack of access to health care leads to death.<sup>97</sup>

### ***Gendered impacts***

49. The neoliberal conception of health as an individual responsibility, an opportunity for profits and an area increasingly left to the free market rather than the welfare state has been acutely felt for decades by women and all those pushed to the margins of society, and its effects have been put into sharp focus since the beginning of the COVID-19 pandemic.

50. The neoliberal perception and enforcement of health as a zero-sum game can be directly linked to the patriarchal de-prioritization of services and resources essential to women and girls’ bodily autonomy, both during and outside of pandemics.<sup>98</sup> The organisation, design, financing of health systems in all parts of

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<sup>94</sup> Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on health financing in the context of right to health, 2012, available at <https://undocs.org/A/67/302>, para. 3.

<sup>95</sup> For instance, in Egypt the Constitution-mandated minimum spending of 3% of the GDP on health had been unachieved for several years until 2020, when it was reached not by increasing spending on underfunded aspects, but by broadening the scope of what constitutes “health spending” in the national budget. See <https://eipr.org/en/publications/eipr-launches-study-%E2%80%9C-and-after-covid%E2%80%A6-plight-egyptian-physicians%E2%80%9D>, page 10.

<sup>96</sup> SRI submission to the Office of the High Commissioner on Human Rights for its report on maternal mortality and morbidity (2020).

<sup>97</sup> Nabil Ahmed: “Inequality Kills: The unparalleled action needed to combat unprecedented inequality in the wake of COVID-19.” Oxfam International, January 2022. <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621341/bp-inequality-kills-170122-en.pdf;jsessionid=0357E79A4E1055BF74247BF3657969CE?sequence=9>, page 12 ; <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621341/tb-inequality-kills-methodology-note-170122-en.pdf>, page 15.

<sup>98</sup> Joint civil society statement on abortion, delivered during the 45<sup>th</sup> session of the UN Human Rights Council and endorsed by 354 organizations and 643 individuals:

the world is illustrative of the lack of priority and attention afforded to women's health and rights.<sup>99</sup> Maternal health is a telling example. As noted by the Special Rapporteur on Violence against Women in her analysis on obstetric violence, “[i]n the context of maternal and reproductive healthcare, the conditions and constraints of the health system are the root causes of mistreatment and violence against women during childbirth.”<sup>100</sup> The OHCHR has also stressed that “[h]ealth systems are more than delivery apparatus for interventions and commodities. A society in which rich and poor women alike – irrespective of race, ethnicity, caste, disability or other characteristics – can rely on the health system to meet their sexual and reproductive health needs fairly is a more just society”<sup>101</sup> and that “[w]hile the prevention of maternal mortality and morbidity often depends on the provision of relatively economical and simple interventions, deaths cannot be fully prevented without an overall functioning health system and a stable infrastructure for transportation of implements and patients, as well as a system for education, the provision of information, and accountability.”<sup>102</sup>

51. For many women then, dysfunctional health systems combine with and compound the systemic and institutional discriminations present in every society. The impact of privatisation means that profit is prioritised over the rights of patients, treated instead as customers who are prioritised according to buying/bargaining power. This automatically means that marginalised groups with less buying power do not have access to health services and are further marginalised as a result. They are often turned away or accrue significant debts to access basic health care because privatisation is always accompanied by erosion of social services increasing morbidity. Preventable maternal mortality and morbidity can then be understood as a form of violence intricately linked to the inadequacy of health systems and health financing, compounded by discrimination based on gender, race, caste, class, sexuality and gender non-conformity among other grounds, and by the criminalisation and environment of fear created by state and non-state actors to regularly result in the violation of

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<https://www.sexualrightsinitiative.com/resources/hrc-45-joint-civil-society-statement-abortion>

<sup>99</sup> Office of the High Commissioner of Human Rights, *Technical Guidance on the application of human rights based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity. Report of the Office of the High Commissioner of Human Rights*, July 2012, [A/HRC/21/22](https://www.ohchr.org/EN/HRBodies/HRC/Reports/HRC21_22/Pages/ID%2044-53.aspx), paras 44 - 53

<sup>100</sup> Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence: <https://undocs.org/A/74/137>, para. 39.

<sup>101</sup> Office of the High Commissioner of Human Rights, *Technical Guidance on the application of human rights based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity. Report of the Office of the High Commissioner of Human Rights*, July 2012, [A/HRC/21/22](https://www.ohchr.org/EN/HRBodies/HRC/Reports/HRC21_22/Pages/ID%2016.aspx), para. 16.

<sup>102</sup> United Nations Office of the High Commissioner for Human Rights, *Preventable Maternal Mortality and Morbidity and Human Rights*, <https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportMaternalMortality.pdf>, para. 43.

many women's and girls' basic right to life before, during and post pregnancy.<sup>103</sup> There are many manifestations of these multiple factors and each represents the state's failure to prioritise and address the systemic failures in the health systems, putting women and girls' lives and well-being at risk.<sup>104</sup>

### ***Critique of international aid***

52. International cooperation is a core human rights principle agreed to by states<sup>105</sup> and human rights bodies.<sup>106</sup> However, international funding and technical cooperation practices are often harmful to existing health systems and undermine human rights. Generally, "funders fail to focus their activities on the health needs of recipient states and direct assistance towards health systems development, inadequately incorporate the inputs of affected communities in their activities, and attach conditionalities to the receipt of funding for health."<sup>107</sup> International health financing is not designed to make existing domestic health systems sustainable. On the contrary, it has the impact of making health financing reliant only on international financing. Consequently, changes in donor priorities require overhauling health infrastructure in the recipient country.<sup>108</sup> This results in an absence of sustained, well-developed, context-specific, available, accessible, acceptable and quality institutions and commodities for people. In the case of women's and girls' health this is linked to the ways in which health systems are not adequately equipped to deal with health complications linked to pregnancy, and to the fact that bodily autonomy is not the basis for health options. Traditional systems in global south states are upended to "modernise" without adapting to the context of these states. Some examples include the kinds of contraception available and pushed into global south economies, and the dismantling of traditional birth attendant systems instead of training or adapting the existing systems, among others.<sup>109</sup> The Special

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<sup>103</sup> SRI submission to the Office of the High Commissioner on Human Rights for its report on maternal mortality and morbidity (2020).

<sup>104</sup> *Ibid.*, para. 8.

<sup>105</sup> See *e.g.* Human Rights Council Resolution 39/10: Preventable maternal mortality and morbidity and human rights in humanitarian settings, A/HRC/RES/39/1, available at [https://ap.ohchr.org/documents/dpage\\_e.aspx?si=A/HRC/RES/39/10](https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/RES/39/10)

<sup>106</sup> Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12): <https://www.refworld.org/pdfid/4538838d0.pdf>

<sup>107</sup> Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on health financing in the context of right to health, 2012, available at <https://undocs.org/A/67/302>, para. 23.

<sup>108</sup> One of the most prominent examples illustrating this phenomenon is the reinstatement of the Mexico City Policy also known as the Global Gag Rule by the United States of America. See *e.g.* <https://www.ippf.org/global-gag-rule>; <https://www.hrw.org/news/2018/02/14/trumps-mexico-city-policy-or-global-gag-rule>

<sup>109</sup> SRI submission to the Office of the High Commissioner on Human Rights for its report on maternal mortality and morbidity (2020).

Rapporteur has rightly called attention to the colonial geopolitics and power disparities in the area of sexual and reproductive health and rights financing.<sup>110</sup>

53. More generally, there is growing research showing the negative impact of aid from Northern states to African states on poverty and growth in recipient countries, while profiting donor countries.<sup>111</sup> Jason Hickel has called “aid in reverse” this phenomenon by which the flow of money (including in the form of aid, foreign investment, and income from abroad) from wealthy countries to developing countries (1.3 trillion dollars in 2012) is far outweighed by the opposite flow of money from developing to wealthy countries (3.3 trillion dollars in 2012), most of which comes from debt repayments and interests, profits made by Northern persons and companies on investments in Global South countries, and evasion of local tax by corporations moving their money to tax havens.<sup>112</sup>

### ***Role of international financial institutions***

54. Despite the damage caused by IMF-imposed austerity and structural adjustment over the past four decades, including following the 2008 financial crisis, the same policies are being “normalized” across the world.<sup>113</sup> This, at the height of a COVID-19 crisis whose effects were aggravated by decades of cuts in public spending, and which has led to many Global South states taking out emergency loans to respond to the crisis. Oxfam research has found that austerity measures were part of the plans indicated in 85% of the 107 COVID-19 loans negotiated between the IMF and 85 countries as of March 2021, which means that at least 73 countries will face IMF-backed austerity in years to come<sup>114</sup> and that inequality both between and within countries will worsen as a result.<sup>115</sup>

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<sup>110</sup> Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng: Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic. <https://undocs.org/en/A/76/172>, para. 6.

<sup>111</sup> See e.g. Moyo, Dambiso. 2009. *Dead aid: why aid is not working and how there is a better way for Africa*. New York: Farrar, Straus and Giroux

<sup>112</sup> See Hickel, John. 2017. *Aid in reverse: how poor countries develop rich countries*. The Guardian. <https://www.theguardian.com/global-development-professionals-network/2017/jan/14/aid-in-reverse-how-poor-countries-develop-rich-countries>

<sup>113</sup> International Trade Union Confederation: “The IMF’s Renewed Supply-Side Push: Four decades of structural adjustment and austerity conditionality” (2020), page 38. Available at <https://www.ituc-csi.org/imf-renewed-supply-side-push>

<sup>114</sup> Nona Tamale: “Adding fuel to fire: How IMF demands for austerity will drive up inequality worldwide.” Oxfam International, August 2021. <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621210/bp-covid-loans-imf-austerity-110821-en.pdf?sequence=1>, page 3.

<sup>115</sup> Nabil Ahmed: “Inequality Kills: The unparalleled action needed to combat unprecedented inequality in the wake of COVID-19.” Oxfam International, January 2022. <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621341/bp-inequality-kills-170122-en.pdf?jsessionid=0357E79A4E1055BF74247BF3657969CE?sequence=9>, page 2.

55. Despite the well-documented adverse gendered impacts of these austerity measures and of the pandemic, including regarding gender-based violence, research by the University of Columbia into COVID-19 response funding streams has shown that “International Financial Institutions (IFIs) were the largest source of COVID response financing but earmarked almost no funding for GBV or SRHR,”<sup>116</sup> and neither did private foundations, while “most bilateral donors were slow to earmark new GBV and SRHR funding.”<sup>117</sup>

**Question 8: 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.**

56. If and when implemented by States, multilateral institutions and the human rights system, the following recommendations would constitute good practices:

57. **On identity politics and violence:** Define violence in the broadest terms so as to include as many affected people as possible; focus on structural and root causes of gender-based violence as well as individual instances; use the framework of gender-based violence instead of narrow identity-based categories; and avoid any hierarchies between forms of violence and their harms, and between survivors.

58. **On structural violence:** Review and change laws, policies and practices that enact, enable, sanction and perpetuate structural violence, within and outside the health system; and adopt an intersectional and rights-based approach to violence that addresses white supremacy, patriarchy, ableism, capitalism and other systemic oppressions and determinants of health in law and practice.

59. **On the harms of protectionist and carceral approaches:** Challenge and draw attention to the harms of protectionist and carceral measures. Invest in systemic approaches to prevent and address gender-based violence without relying on incarceration, such as re-distributive justice.

60. **On the criminalisation of sex work, abortion and other aspects of sexuality:** Remove all laws and policies criminalizing or otherwise punishing abortion, contraception, adolescent sexuality, same-sex conduct, and sex work<sup>118</sup> and therefore violating the rights to health and to bodily autonomy. Ensure full and meaningful participation of women human rights defenders and all affected persons, including sex workers, before drafting and enacting new laws and policies that affect them.

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<sup>116</sup> This research focused on the funding streams for 5 countries: Colombia, Kenya, Nigeria, South Africa and Uganda, between January and July 2020. See [https://www.publichealth.columbia.edu/sites/default/files/multi-country\\_funding\\_2-pager\\_9\\_april\\_2021.pdf](https://www.publichealth.columbia.edu/sites/default/files/multi-country_funding_2-pager_9_april_2021.pdf)

<sup>117</sup> *Ibid.*

<sup>118</sup> See for instance <https://undocs.org/A/HRC/14/20> and <https://undocs.org/A/66/254>

61. **On health systems and financing:** Strengthen and finance public health systems through taxation and free from control from other governments, multilateral agreements and transnational corporations. This requires donor states, international financial institutions and other creditors and donors to adhere to human rights and ensure that financial and other assistance is sustainable, designed with meaningful participation of local feminist movements, and does not depend on any conditionality such as austerity measures, privatization and structural adjustments.<sup>119</sup>

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<sup>119</sup> See *e.g.* Special Rapporteur on the Right to Health, Report on health financing in the context of the right to health, A/67/302, para 28; and Independent Expert on Foreign Debt, COVID-19: Urgent appeal for a human rights response to the economic recession, page 12.

This was part of the recommendations made by 354 organizations and 643 individuals in a joint statement on abortion delivered to the Human Rights Council in September 2020:

<https://www.sexualrightsinitiative.com/resources/hrc-45-joint-civil-society-statement-abortion>