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**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development****Violence and its impact on the right to health****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***Summary*

In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, sheds light on who is seen as a victim of violence, with emphasis on the violence experienced by women, children and non-binary people and on conflict-related sexual violence and structural violence. She adopts a substantive equality approach and analyses violence and its impact on the right of everyone to the highest attainable standard of physical and mental health within intersectional, anti-racism and anti-coloniality frameworks.

In seeking to end and respond to violence she proposes an intersectional, non-discriminatory and gender (non-binary) approach that understands gender-based violence as a phenomenon that includes matters of sexuality, and violations against persons on the basis of their real or imputed sexual orientation, gender identity and sex characteristics. She underscores that a non-binary approach to gender and gender-based violence is well-rooted in international human rights law.

The Special Rapporteur also clarifies the legal obligations that arise under the right to health framework in addressing violence and reports on examples of responses, with a focus on good practices.



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I. Introduction: a substantive equality approach to violence and its impact on the right to health

1. Health and violence can intersect in multiple ways. On the one hand, violence has major health consequences, including injuries and death, mental illness and suicide, and an increased risk of chronic health issues,¹ which in turn give rise to health-care needs for survivors.² On the other hand, violence permeates health systems themselves; in health facilities, violence may be perpetrated by providers or against them.³ Overall, violence may become institutionalized at the hands of both State and non-State agents when government authorities fail to act with due diligence, taking little to no action to adequately prevent it or respond to it.⁴

2. Over the years, the health situation across the world has undergone dramatic changes and so has the notion of health, which has grown to encompass such socially related concerns as violence and armed conflict.⁵ Violence comes in various forms: for example, within families, intimate partner violence remains pervasive, and was intensified by coronavirus disease (COVID-19) lockdowns;⁶ brutality by State agents, including police, endures in democracies and dictatorships alike;⁷ and discrimination against marginalized groups frequently arises to levels of violence.⁸ Globally, violence-related injuries kill 1.25 million people every year,⁹ but death and the burden of disease are not evenly distributed across or within countries, with some people being more vulnerable than others depending on the conditions in which they are born, grow, live and age.¹⁰ For instance, persons with disabilities are three times more likely to experience physical, sexual and emotional violence than persons without disabilities.¹¹

3. The Special Rapporteur, Tlaleng Mofokeng, has adopted a substantive equality approach. In that light, she has prioritized the analysis of violence and its impact on the right of everyone to the highest attainable standard of physical and mental health, within intersectional, anti-racism and anti-coloniality frameworks.¹²

4. Substantive equality, an approach that underscores the need to ensure true equality in outcomes, is rendered unattainable where violence prevails. The many different forms of violence, ranging from interpersonal to societal and structural, are often rooted in intersectional forms of discrimination, not only on the bases of age, race, class, ethnicity, sex, gender, sexual orientation, gender identity, sex characteristics and disability, but also in situations of vulnerability: poverty, health or migration status, homelessness and drug use, living in residential institutions or in conflict or post-conflict situations. They do not originate in a vacuum but in contexts of inequality and multiple forms of discrimination.

5. In ending and responding to violence, a substantive equality approach to the right to health requires adopting an intersectional, non-discriminatory and gender (non-binary)

¹ <https://www.who.int/news-room/fact-sheets/detail/injuries-and-violence>.

² Ibid.

³ <https://www.who.int/news-room/feature-stories/detail/attacks-on-health-care-in-the-context-of-covid-19>; World Health Organization (WHO), *Global strategy on human resources for health: Workforce 2030* (2016) <https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf>.

⁴ Inter-American Court of Human Rights, *V.R.P., V.P.C. et al v. Nicaragua*, Preliminary Objections, merits, reparations and costs, Judgment, 2018.

⁵ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 10.

⁶ United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), <https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/Issue-brief-COVID-19-and-ending-violence-against-women-and-girls-en.pdf>.

⁷ Office of the United Nations High Commissioner for Human Rights (OHCHR), “UN experts call for an end to police brutality worldwide” (11 August 2021). See <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=27376&LangID=E>.

⁸ OHCHR, <https://www.ohchr.org/EN/Issues/Health/Pages/GroupsInVulnerableSituations.aspx>.

⁹ See <https://www.who.int/news-room/fact-sheets/detail/injuries-and-violence>.

¹⁰ Ibid.

¹¹ https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-WEI_Guidelines_Disability_GBV_SRHR_FINAL_19-11-18_0.pdf.

¹² [A/HRC/47/28](#), para. 9.

approach.¹³ A holistic response to violence must address the ways in which violence manifests in different contexts (conflict, displacement and the like), locations (for example, urban/rural) and in people with different age, sex, gender, sexual orientation, gender identity, sex characteristics and abilities. The approach requires further examination of how such a holistic response interrelates with race, ethnicity, minority, political, social, economic or other status and survivors' experience of multiple and intersectional forms of discrimination. It is about addressing violence against the person, mindful of situations of vulnerabilities, discrimination and exclusion linked to belonging to specific groups, categories or situations, and avoiding category-based responses that forget intragroup differences and intersections.

6. A substantive equality approach to the right to health when responding to violence requires being knowledgeable and addressing common root causes of violence entrenched in patriarchy, systems of oppression, systemic racism, inequalities and binary approaches to gender. It requires also identifying the legacy of colonialism and coloniality.

7. In striving towards realizing the right of everyone to the highest attainable standard of physical and mental health, approaches to preventing and responding to violence that take the plurality of human experiences into account must remain a priority. To achieve substantive equality, laws and practices that enable violence must be repealed and denounced.

II. Methodology

8. The present report is based on information received on the impact of violence on the right to health, on the analysis of the joint communications sent on this matter and on relevant literature.

9. Since the establishment of the mandate in April 2002, successive Special Rapporteurs on the right to health have sent 1,168 joint communications on alleged violations of the right to health, of which 766 related to violence. Since she assumed her mandate in 2020, the Special Rapporteur has sent 144 joint communications to 76 countries across regions concerning various forms of violence against women, girls, men, boys and non-binary persons. Communications included cases of alleged violations of the right to health in connection with conflict-related violence, including sexual violence,¹⁴ in the context of violence by law enforcement agents and in detention (also against persons with disabilities and children),¹⁵ as well as cases of sexual and reproductive health rights¹⁶ and of

¹³ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 18.

¹⁴ Communications OTH 80/2020, PAN 1/2020, SRB 4/2020, SYR 3/2020, TUR 16/2020, BLR 9/2021, CHE 4/2021, EGY 13/2021, ERI 4/2021, ETH 2/2021, LBY 3/2021, POL 5/2021, TUN 6/2021, TUN 8/2021, AUS 1/2022, AUT 1/2022, DEU 1/2022, FRA 1/2022, GBR 1/2022, SWE 1/2022 and USA 2/2022.

¹⁵ Communications AZE 1/2020, BGD 7/2020, BOL 4/2020, CHN 21/2020, COM 1/2020, EGY 15/2020, EGY 16/2020, EGY 18/2020, IRN 21/2020, ISR 6/2020, KHM 9/2020, MDG 3/2020, MEX 14/2020, OTH 66/2020, QAT 2/2020, RUS 5/2020, SAU 13/2020, TUR 23/2020, USA 31/2020, VEN 11/2020, VEN 5/2020, VEN 7/2020, ARE 1/2021, BGD 2/2021, BHR 2/2021, BHR 4/2021, BHR 5/2021, CAN 8/2021, CHN 12/2021, CHN 4/2021, CHN 5/2021, COM 1/2021, CPV 2/2021, DZA 2/2021, EGY 10/2021, EGY 12/2021, EGY 14/2021, EGY 15/2021, EGY 5/2021, EGY 8/2021, ERI 3/2021, IND 10/2021, IND 11/2021, IRN 12/2021, IRN 13/2021, IRN 14/2021, IRN 16/2021, IRN 18/2021, IRN 2/2021, IRN 31/2021, ISR 2/2021, KEN 5/2021, KGZ 3/2021, KHM 9/2021, MAR 6/2021, MDG 1/2021, NGA 2/2021, NGA 5/2021, NIC 3/2021, OTH 190/2021, OTH 250/2021, OTH 6/2021, PAK 10/2021, PAK 4/2021, PER 5/2021, SAU 6/2021, SGP 3/2021, SOM 1/2021, TGO 4/2021, TUR 1/2021, TUR 13/2021, TUR 9/2021, UGA 5/2021, USA 17/2021, VNM 6/2021, IRN 1/2022, ISR 1/2022 and SGP 1/2022.

¹⁶ Communications ARG 4/2020, BRA 9/2020, KEN 4/2020, KOR 8/2020, OTH 87/2020, SOM 1/2020, USA 34/2020, BRA 12/2021, BRA 5/2021, CHL 4/2021, CHN 6/2021, COL 1/2021, DEU 5/2021, DOM 2/2021, ESP 6/2021, GTM 13/2021, ISR 6/2021, MEX 2/2021, OTH 194/2021, OTH 195/2021, OTH 196/2021, OTH 197/2021, OTH 198/2021, OTH 199/2021, USA 22/2021, USA 25/2021 and VEN 1/2021.

discrimination and gender based-violence based on real or imputed sexual orientation, gender identity and expression.¹⁷

10. In preparing the present report, the Special Rapporteur issued a call for written submissions, inviting relevant stakeholders. She expresses her appreciation to all who contributed to the report.¹⁸

III. Legal framework

11. Violence is a major obstacle in the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including the right to sexual and reproductive health and may, depending on the context, amount to violations of a number of human rights, including the rights to life, health, freedom from discrimination, equal protection under the law, freedom from torture and from cruel, inhuman or degrading treatment, and the right to just and favourable work conditions.

12. Ending all forms of violence against the person is a global commitment of States under the 2030 Agenda for Sustainable Development.¹⁹ It also touches on legal obligations emanating from general international law and relevant human rights treaties, under which States may incur responsibility for acts or omissions of violence, such as gender-based violence or violence against children, either because State actors engage in those forms of violence, or because the acts or omissions of private actors become attributable to the State. A State may also violate its human rights obligations when it fails in its due diligence to prevent violations of rights or to investigate and punish acts of violence, or provide compensation.²⁰

13. The right to health is an important part of the robust human rights framework that aims to prevent violence and protect everyone from all its forms, and ensure accountability and redress.

14. As clarified by the Committee on Economic, Social and Cultural Rights, the right to health contains important freedoms, such as the right to control and make decisions on one's body and health free of violence, coercion and discrimination, as well as key entitlements, including the right to equal access to health facilities, goods and services free of discrimination on any grounds. The right to health extends to and is affected by the underlying determinants of health, such as access to safe and potable water and sanitation as well as such other social determinants of health as gender difference. It also takes into account social concerns, in particular violence and armed conflict.²¹ The above-mentioned determinants affect all persons. For many women, girls and LGBTIQ+ people,²² gender-based social and cultural norms act as an additional social determinant of health that seriously impacts their enjoyment of the right to health and other human rights.

15. The Committee affirms that the right to health extends to effective protection from all forms of violence, torture and discrimination against all persons and from all gender-based expressions of violence. It also requires preventive, promotional and remedial action to shield

¹⁷ Communications HUN 3/2020, OTH 88/2020, OTH 89/2020, POL 1/2020, ROU 3/2020, TZA 4/2020, BGR 1/2021, GHA 3/2021, GTM 10/2021 and HUN 1/2021.

¹⁸ For submissions received, see <https://www.ohchr.org/en/calls-for-input/calls-input/call-contributions-violence-and-its-impact-right-health>.

¹⁹ General Assembly resolution 70/1, targets 5.2, 5.3, 16.1 and 16.2.

²⁰ See Universal Declaration of Human Rights; International Covenant on Economic, Social and Cultural Rights; International Covenant on Civil and Political Rights; Convention on the Elimination of All Forms of Discrimination against Women; and Convention on the Rights of the Child. See also Human Rights Committee, general comment No. 31 (2004), para. 8; and General Assembly resolution 56/83 on the responsibility of States for internationally wrongful acts (annex, articles 4 and 8).

²¹ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras 8, 10 and 18, and general comment No. 22 (2016) para. 5.

²² LGBTIQ+ is an acronym for lesbian, gay, bisexual, transgender, intersex and queer persons. The plus sign represents persons with diverse sexual orientation, gender identity, gender expression and sex characteristics who identify with other terms.

all individuals from the harmful practices and norms and gender-based violence that deny them their full sexual and reproductive health.²³

16. While protection extends to all forms of violence against the person, the Committee has made explicit reference to the obligation to protect from violence persons in vulnerable or marginalized situations, in particular women, children, adolescents and elder persons, and those working in the sex industry.²⁴ In that connection, the Committee has recognized women's experience of violence throughout their lives (for example, when seeking abortion or post-abortion care)²⁵ and during conflict, when trafficked and sexually exploited,²⁶ as well as violence against children (for example, harmful practices, trafficking and sexual exploitation),²⁷ LGBTI persons (for example, irreversible and involuntary surgery and treatment performed on intersex infants or children)²⁸ and persons with disabilities.²⁹

17. The Committee has emphasized the importance of addressing and overcoming the exacerbated impact of multiple and intersecting forms of discrimination on the enjoyment of the right to health and substantive equality,³⁰ which, the Special Rapporteur underlines, is of particular relevance for survivors of violence.

18. The obligation to respect requires that States refrain from directly or indirectly interfering with the right to health, such as refraining from applying coercive medical treatments (such as forced sterilization, or involuntary surgery on intersex persons), or refraining from engaging in police brutality. Importantly, the denial of access to health facilities, goods and services to particular individuals or groups, including survivors of violence, as a result of de jure or de facto discrimination, would be a violation of the obligation to respect the right to health. When survivors of gender-based violence, including sexual violence, are faced with such barriers, the obligation to respect the right to sexual and reproductive health would also be violated.³¹ Examples of such barriers would include the banning of contraceptives, or the criminalization of abortions and of consensual sexual activity between adults.

19. As mentioned above, the obligation to protect requires States to protect against all forms of violence, including preventing third parties from coercing women to undergo such traditional practices female genital mutilation and from interfering with the enjoyment of the right to health. Protection could be achieved by enacting and enforcing laws and policies

²³ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 21, and general comment No. 22 (2016), paras. 22 and 29.

²⁴ *Ibid.*, general comment No. 14 (2000), para. 35, and general comment No. 22 (2016), para. 32. In its concluding observations on the combined second to fifth periodic reports of Kenya ([E/C.12/KEN/CO/2-5](#), para. 37), the Committee set out its concerns regarding pervasive domestic violence in that country; and in its concluding observations on the sixth periodic report of Norway ([E/C.12/NOR/CO/6](#)), it highlighted the issue of violence against older persons in domestic and institutional settings in Norway.

²⁵ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 26.

²⁶ *Ibid.*, para. 30.

²⁷ Committee on Economic, Social and Cultural Rights; see, for example, concluding observations on the initial to third reports of the United Republic of Tanzania ([E/C.12/TZA/CO/1-3](#)).

²⁸ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 59; concluding observations on the fifth periodic report of Belgium ([E/C.12/BEL/CO/5](#)); and concluding observations on the second periodic report of Kazakhstan ([E/C.12/KAZ/CO/2](#), para. 48), regarding violence in schools, against LGBTI students in Kazakhstan.

²⁹ Committee on Economic, Social and Cultural Rights, concluding observations on the fourth periodic report of New Zealand ([E/C.12/NZL/CO/4](#)), regarding the protection of children with disabilities, Maori women and children from violence. See also Concluding observations on the fifth periodic report of Australia ([E/C.12/AUS/CO/5](#)), concerning violence against persons with disabilities in institutional and residential settings.

³⁰ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) para. 32.

³¹ Committee on Economic, Social and Cultural Rights., general comment No. 14 (2000), paras. 32–34; and general comment No. 22 (2016) paras. 40 and 57.

prohibiting violence and discriminatory practices, including the legal prohibition of harmful practices and gender-based violence.³²

20. The Committee stresses that the failure to take all necessary measures to protect women against violence, to prosecute perpetrators or to discourage harmful traditional medical or cultural practices is a violation of the obligation to protect the right to health. States violate the right to health when they fail to take effective steps to prevent third parties from undermining the enjoyment of the right to sexual and reproductive health, in particular in relation to domestic violence, rape (including marital rape), sexual assault, abuse and harassment, including during conflict, post-conflict and transition situations; violence targeting LGBTIQ+ persons or women seeking abortions or post-abortion care; harmful practices such as female genital mutilation, child and forced marriage, forced sterilization, forced abortion and forced pregnancy; and medically unnecessary, irreversible and involuntary surgery and treatment performed on intersex infants or children.³³

21. The obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health, for example, through policies, action plans, or programmes to prevent, respond and redress violence.³⁴ Specifically, the Committee requires States to guarantee physical and mental health care for survivors of sexual and domestic violence in all situations, including access to post-exposure prevention, emergency contraception and safe abortion services³⁵ and to undertake information campaigns, in particular with respect to sexual and reproductive health, traditional practices, and domestic violence.³⁶ The Special Rapporteur notes that such obligations would extend to other forms of violence and notes that providing insufficient public resources or their misallocation, resulting in the non-enjoyment of the right to health for individuals or groups, particularly those in a vulnerable or marginalized situation such as survivors of violence, or the failure to adopt a (non-binary) gender approach to health would amount to a violation of the right to health, including sexual and reproductive health.

22. The Special Rapporteur stresses that any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels,³⁷ and underlines that access to health services should be provided as part of reparation programmes for sexual violence survivors, especially for conflict-related sexual violence.³⁸

IV. Gender and gender-based violence: an inclusive (non-binary) approach

23. The Special Rapporteur underlines the criticality of adopting a non-binary approach to gender and gender-based violence under the right to health.

³² Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) para. 35; and general comment No. 22 (2016), paras. 41 and 49 (d).

³³ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 51; and general comment No. 22 (2016), para. 59.

³⁴ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 33; and general comment No. 22 (2016), para. 45.

³⁵ Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 45.

³⁶ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 36; and general comment No. 22 (2016), para. 45.

³⁷ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 59.

³⁸ International Criminal Court, *The Prosecutor v. Bosco Ntaganda*, No. ICC-01/04-02/06, Public Reparations Order of 8 March 2021, in which the Court recognizes that certain victims, including victims of sexual or gender-based violence, as well as children born out of rape and sexual slavery, need priority treatment for immediate physical and/or psychological medical care (paras. 87, 93, 214 and 240), and recognized reparations as collective (paras. 78–81, 186 and 193), https://www.icc-cpi.int/CourtRecords/CR2017_05121. In *Guatemala v. Estelmer Francisco Reyes Giron y Heriberto Valdez Asig*, known as the Sepur Zarco case, the High Risk Tribunal of Guatemala (Judgment C-01076-2012-00021) ordered the construction of a health centre as part of reparations.

24. This is not only the right thing, from an inclusive and substantive equality approach to the right to health, but it is sustained in a robust body of human rights law instruments, jurisprudence, and materials, in which the term gender is used to describe the sociocultural constructs that assign roles, behaviours, forms of expression, activities and attributes according to the meaning given to biological sex characteristics.³⁹ The Special Rapporteur shares the view of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity that nothing in that definition equates the terms gender and women or sex and gender; underscores the evidence-based analysis that under international human rights law, the use of the terms gender and gender identity and expression includes all persons, communities and populations; and welcomes progress made by international and regional human rights bodies in this regard.⁴⁰

25. Gender-based violence should be addressed through a non-binary approach that is cognizant of it being a phenomenon that includes matters of sexuality, and violations against persons on the basis of their real or imputed sexual orientation, gender identity and sex characteristics. The binary conceptualization of gender as strictly being heteronormative creates an assumption that shapes how LGBTIQ+ persons navigate social, political, economic and legal structures, including those directly relating to gender-based violence⁴¹ and is one of the root causes of the particularly brutal forms of gender-based violence, hate crimes and hate speech they face.

26. The intersections of gender and sexuality show misogynistic violence as a prevailing culture of patriarchal control and violence that affects all women, LGBTIQ+ people and children. An approach that considers violence solely based on binary gender risks protecting only cisgender women and girls, whether heterosexual, lesbian, or bisexual, excluding transgender women and other persons perceived as non-conforming, and may be based wrongly on the assumption that violence is always perpetrated by the male gender.

27. The Special Rapporteur underscores the need to expand the scope of the definition of gender-based violence to include violence based on sexuality, sexual orientation, gender identity and sex characteristics, thereby including all cisgender,⁴² queer, intersex and transgender women and feminine presenting people.

28. As noted by the Special Rapporteur on Violence against Women, no form of interpersonal violence against women is devoid of structural violence, and violence against women is not the root problem, but occurs because other forms of discrimination are allowed to flourish. Patriarchal, racist, ableist, homophobic, transphobic and capitalist oppressions are part of the continuum of violence and of the conditions facilitating, enabling and perpetuating violence.

29. Gender-based violence can be defined as harmful acts targeting individuals based on their gender, understood as socially constructed identities, attributes and roles for women and men and society's social and cultural meaning for those biological differences.⁴³ It can include physical and psychological abuse, threats, coercion, and economic or educational deprivation, whether occurring in public or private life. Gender-based violence is rooted in the unequal power relationships within the binary approach to gender, which is reflected in societal norms and expectations, and situational instances of power imbalances enabled by patriarchy.

30. In addition to the well-documented health impacts of gender-based violence, the routine denial of bodily autonomy for women and LGBTIQ+ gender-non-conforming people, constitutes a widespread and pervasive form of gender-based structural and institutional violence.

³⁹ A/HRC/47/27, paras. 13–14.

⁴⁰ Ibid., paras. 14 and 21–26.

⁴¹ C. Ngwena, *What is Africanness? Contesting Nativism in Race, Culture, and Sexualities* (Pretoria, Pretoria University Law Press, 2018), p. 204

⁴² Describes people whose sense of their own gender is aligned with the sex assigned at birth.

⁴³ See Inter-American Court of Human Rights, https://www.corteidh.or.cr/docs/opiniones/seriea_24_eng.pdf, para. 16.

V. Multiple forms of violence

A. Gender-based violence based on real or imputed sexual orientation, gender identity, gender expression and sex characteristics

31. Gender in many societies is viewed within a strict binary lens that has entrenched the hegemonic conceptualization of sexuality as being strictly heteronormative.⁴⁴ Through this heteronormative conceptualization of gender and sexuality, society has produced and reproduced societal structures, institutions, and norms that are inherently “cishnormative”, including those relating to human rights.⁴⁵

32. Violence targeting people based on their real or perceived sexual orientation, gender identity, gender expression, and sex characteristics is widespread globally.⁴⁶ Rooted in the desire to punish people whose identities, expressions and bodies do not conform to the heteronormative, man/woman binary system, this violence manifests in acts (attacks, arrests, rape, torture, murder) that are often committed or condoned by State actors. Violence against LGBTIQ+ persons is institutionalized by prejudiced systems grounded in laws and policies that impede or forbid the exercise of one’s own personhood. In many countries, discriminatory laws and practices in effect today derive from British, Spanish or French colonial systems, which marks a major shift from many precolonial cultures that were open to gender and sexual plurality.⁴⁷

33. The Special Rapporteur notes with concern that, in general, health-care workers worldwide are infrequently trained to meet the sexual and reproductive health-care needs of lesbian, gay, bisexual, transgender and intersex individuals.⁴⁸ As a result of the widespread violence, discrimination and rejection that they face, including from within their families and communities, LGBTIQ+ youth experience higher levels of mental health disorders, with suicide attempts 3–7 times more likely for LGBTIQ+ youth compared with heterosexual youth. LGBTIQ+ persons suffer more from anxiety and depression, are more likely to misuse tobacco and alcohol, and face higher risks of heart disease, stroke and many forms of cancer.⁴⁹

34. Factors such as ethnicity, race, sex, gender, migration status, age, and poverty play a significant role in one’s health.⁵⁰ Nevertheless, these disparities in enjoyment of the right to health are all tied to prejudice, abuse and violence owing to exclusion from social systems, education systems and formal economies under which most people enjoy professional and personal protection. Such disparities are therefore all preventable.

35. The abuse and violation experienced by sex workers in general includes a significant proportion of LGBTIQ+ people, who are further targeted and abused for their real or imputed sexual orientation, gender identity, gender expression and sex characteristics. Under such conditions, abuse of LGBTIQ+ sex workers would normally not be recorded as gender-based violence, leaving a gap in the understanding of the violence and who is affected.⁵¹

36. LGBTIQ+ people including non-binary individuals, often do not feel safe reporting violation to authorities for fear of secondary victimization. Official documentation often does not allow for recording gender categories outside of man and woman, preventing victims of violence from communicating their experiences as specifically gendered.

⁴⁴ C. Ngwena, *What is Africanness?* p. 204.

⁴⁵ Ibid.

⁴⁶ See

https://www.ohchr.org/sites/default/files/Documents/Publications/Born_Free_and_Equal_WEB.pdf, chap. 1.

⁴⁷ A/HRC/38/43 (2018) and A/HRC/47/27 (2021).

⁴⁸ Mariella Munyuzangabo, and others, “Delivery of sexual and reproductive health interventions in conflict settings: a systematic review” (BMJ Global Health vol. 5 (Suppl. 1), 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7375437/>.

⁴⁹ See <https://www.hhrguide.org/2014/03/18/how-is-health-a-human-rights-issue-for-lgbti-persons/>.

⁵⁰ Inter-American Commission on Human Rights, *Violence against Lesbian, Gay, Bisexual, Trans and Intersex Persons in the Americas* (2015).

⁵¹ Inter-American Court of Human Rights, *Vicky Hernández et al. v. Honduras*, 2021.

37. Violence against LGBTIQ+ persons occurs in both public and private spaces, by both State agents (police, militia, and the like),⁵² and non-State agents (such as family members, mobs, gangs and religious extremists). Regardless of the perpetrator, this violence is condoned by States when it goes uninvestigated and unaddressed.

38. The Human Rights Committee has repeatedly affirmed the obligation of States to protect persons targeted on account of their sexual orientation or gender identity, which are prohibited grounds of discrimination under the International Covenant on Civil and Political Rights, as well as those who defend LGBTI rights; It has regularly denounced reports of discrimination and violence against LGBTI persons, including by law enforcement, and the barriers they face to access justice and remedies.⁵³ It has established States' obligation to protect individuals from violations of Covenant rights by its agents but also against acts committed by private persons or entities.⁵⁴ In that connection, the Committee has recognized that State parties' permitting or failing to exercise due diligence to prevent, punish, investigate or redress the harm caused by such acts by private persons would give rise to violations of those rights.⁵⁵ Furthermore, the failure by a State party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant.⁵⁶

39. The Inter-American Court of Human Rights has held that States must use due diligence in investigating sexual violence.⁵⁷ In cases of sexual violence against LGBTI persons, the due diligence standard includes the duty for State authorities to take all necessary steps to determine if the violence was motivated by prejudice and discrimination.⁵⁸ The Court has further held that discrimination based on sexual orientation or gender identity fulfils the "motive" element of torture, with the other elements being severity and intent.⁵⁹ Therefore, sexual violence against LGBTI persons grounded in discrimination can amount to torture. Additionally, the Court has ordered more holistic forms of reparations to address sexual violence against LGBTI persons, including that the State provide survivors of violence with financial compensation and physical and psychological rehabilitative services; hold a public ceremony to acknowledge State responsibilities; and provide training within the justice system on LGBTI rights and due diligence investigations.⁶⁰

40. The European Court of Human Rights, in *M.C and A.C v. Romania* (2012) and *Identoba and Others v. Georgia* (2015),⁶¹ found that States' failure to protect persons who participated in peaceful LGBTI demonstrations from homophobic violence and a lack of effective investigations amounted to violations of the prohibition on torture and inhuman or degrading treatment and discrimination.

41. International bodies have found that the above-mentioned forms of violence and the lack of investigations compliant with human rights standards amount to violations of the International Covenant on Civil and Political Rights, the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child.⁶² In a recent decision, *O.N. and D.P. v. Russian Federation*, concerning a lesbian couple subjected to violence, homophobic insults and death threats by two unknown

⁵² A/HRC/47/27 (2021).

⁵³ CCPR/C/KEN/CO/4, para. 13; CCPR/C/KOR/CO/4, paras. 14 and 15; CCPR/C/TGO/CO/5, paras. 17 and 18; and CCPR/C/SLV/CO/7, paras. 9 and 37.

⁵⁴ Human Rights Committee, general comment No. 31 (2004), para. 8.

⁵⁵ Ibid.

⁵⁶ Ibid, para. 15.

⁵⁷ Inter-American Court of Human Rights, *Fernández Ortega et al. v. Mexico*, Preliminary Objections, Merits, Reparations, and Costs, Judgment, 2010.

⁵⁸ Inter-American Court of Human Rights, *Azul Rojas Marín et al. v. Peru*, Preliminary Objections, Merits, Reparations and Costs, Judgment, 2020.

⁵⁹ Ibid.

⁶⁰ See <https://www.ejiltalk.org/discriminatory-torture-of-an-lgbti-person-landmark-precedent-set-by-the-inter-american-court-azul-rojas-marin-and-another-v-peru/>.

⁶¹ See European Court of Human Rights, <https://hudoc.echr.coe.int/eng?i=001-116847>; and <https://hudoc.echr.coe.int/eng?i=001-154400>.

⁶² See <https://ilga.org/Treaty-Bodies-jurisprudence-SOGIESC>.

men, the Committee on the Elimination of Discrimination against Women found violations under the Convention.⁶³

42. In a 2021 case of lethal police violence against a transgender woman in Honduras, the Inter-American Court of Human Rights held for the first time that the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belém do Pará) applied to not only cisgender women but also to transgender women.⁶⁴

B. Gender-based violence against women

43. Gender-based violence against women applies to cisgender and trans women, and is one of the most prevalent human rights violations worldwide.⁶⁵ According to data from 2000–2018 from 161 countries, the World Health Organization (WHO) reports that 1 in 3 women worldwide or around 736 million women, have been subjected to intimate partner physical or sexual violence, non-partner sexual violence or both in their lifetimes.⁶⁶ Intimate partner violence is the most common form of violence against women, with nearly one third of women worldwide between the ages of 15 and 49 reporting that they have been subject to sexual or physical violence by an intimate partner.⁶⁷

44. Global data on gender-based violence against women with disabilities and on harmful practices and violence in obstetric care is limited.⁶⁸ Between 40 and 68 per cent of girls and young women with disabilities experienced sexual violence before the age of 18,⁶⁹ and their forced sterilization is a common practice across the globe.⁷⁰ Mistreatment and violence against women experienced during pregnancy, facility-based childbirth and the postpartum period by medical practitioners, midwives, nurses and hospital staff, also called obstetric violence, is widespread.⁷¹

45. Gender-based violence against women can vastly impact woman's health, leading to injuries, unintended pregnancies, induced abortion, gynaecological problems, obstetric complications, sexually transmitted infections including HIV, mental health illnesses including anxiety and depressive disorders, increased substance misuse, suicide and homicide, among other problems.⁷² The killing of women because of their sex and/or gender, the so-called – femicides, constitutes the most extreme form of violence and most violent manifestation of discrimination against women and a particularly grave form of assault on the right to life.⁷³ According to WHO, 38 per cent of all murders of women are committed by intimate partners.⁷⁴ Although over 155 countries have passed laws on domestic violence, they often go unenforced.⁷⁵ Lockdowns during the COVID-19 pandemic increased exposure to violence and its risk factors.⁷⁶

⁶³ CEDAW/C/75/D/119/2017.

⁶⁴ See <https://www.ejiltalk.org/vicky-hernandez-et-al-v-honduras-a-landmark-victory-with-a-bitter-aftertaste/>.

⁶⁵ See <https://www.friendsofunfpa.org/what-is-gender-based-violence-gbv/>.

⁶⁶ See <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

⁶⁷ Ibid.

⁶⁸ Submission of UNFPA.

⁶⁹ Ibid. See also <https://www.unfpa.org/publications/women-and-young-persons-disabilities>.

⁷⁰ A/72/133, paras. 29–32.

⁷¹ M Hastings, “Pulling back the curtain on disrespect and abuse: the movement to ensure respectful maternity care”, Policy Brief (Health Policy Project, 2015); and A/74/137, paras 4 and 16.

⁷² See <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

⁷³ Human Rights Committee, general comment No. 36 (2019), para. 61; and A/76/132 para. 18.

⁷⁴ <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

⁷⁵ <https://www.unwomen.org/en/what-we-do/ending-violence-against-women>.

⁷⁶ Ibid.; submission of UNFPA; and

<https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/Issue-brief-COVID-19-and-ending-violence-against-women-and-girls-en.pdf>.

46. A number of United Nations instruments aim to more specifically target gender-based violence against women,⁷⁷ and were later on reinforced through the 2030 Agenda, which aims to achieve gender equality and set targets to eliminate violence against women and girls and early and forced marriage.⁷⁸

47. In 2017, the Committee on the Elimination of Discrimination against Women issued general recommendation No. 35 updating general recommendation No. 19, of 1992, and recalled that gender-based violence against women and girls constitutes discrimination under the Convention on the Elimination of All Forms of Discrimination Against Women that as such is a violation of their human rights, and that it is inextricably linked to other factors, including being lesbian, bisexual, transgender or intersex; and to age, race disability, health or socioeconomic status.⁷⁹ The Committee also recognized that women experience varying and intersecting forms of discrimination and gender-based violence in different ways and to different degrees. The Committee affirmed that the prohibition of gender-based violence against women had attained the status of *jus cogens* under international law,⁸⁰ that it may amount to torture or cruel, inhuman or degrading treatment in certain circumstances, including in cases of rape, domestic violence, or harmful practices, among others and that in certain cases, some forms of gender-based violence against women may also constitute international crimes.⁸¹

48. Violence against women who are lesbian is often viewed through the singular lens of heterosexuality and erases the experiences of these women. The failure of comprehensive third-party support is informed by heteropatriarchal attitudes and is re-enacted by third-party responders, which has the effect of silencing survivors of same-sex intimate partner violence. For lesbians, keeping secrets about abuse in relationships is also linked to homophobia and heterosexism: it is still risky for some lesbians to be out, and it can be dangerous to reveal abuse within an already oppressive context.⁸²

49. The Committee has also recognized violations of women's sexual and reproductive health rights as forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment, such as forced sterilizations, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services.⁸³

50. In that connection, the Special Rapporteur underlines that practices that amount to obstetric violence constitute a human rights violation and a form of gender-based violence against women, including the shackling of women during childbirth, or post-childbirth detention of women and their newborns in health-care facilities owing to their inability to pay hospital fees,⁸⁴ and may also amount to torture and ill-treatment, including such practices as the surgical separation and widening of the pelvis to facilitate childbirth⁸⁵ or non-medically needed caesarean sections without a woman's consent.⁸⁶ The Special Rapporteur also underscores the correlation between the criminalization of abortion⁸⁷ and unsafe abortions,

⁷⁷ Committee on the Elimination of Discrimination against Women, general recommendation No. 19 (1992); Declaration on the Elimination of Violence Against Women (General Assembly resolution 48/104); and *Report of the Fourth World Conference on Women, Beijing, 4–15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annexes I and II.

⁷⁸ General Assembly resolution 70/1; see also <https://sdgs.un.org/goals/goal5>.

⁷⁹ Committee on the Elimination of Discrimination against Women, general recommendation No. 19 (1992) paras 1, 6–7, updated by general recommendation No. 35, para. 12.

⁸⁰ *Ibid.*, para. 2.

⁸¹ *Ibid.*, para. 16.

⁸² Lethabo Mailula and Letlhogonolo Mokgoroane, “The bloody rainbow: the creation of the second closet – lesbian Blackwomxn, intimate partner violence and third parties’ responses”, *Acta Juridica*, vol. 2020, No. 1 (September 2020), p. 267.

⁸³ *Ibid.*, para. 18; and [A/HRC/31/57](#), para. 43.

⁸⁴ [A/74/137](#), paras. 12, 22 and 23.

⁸⁵ *Ibid.*, para. 20; see also [CAT/C/IRL/CO/2](#), paras.29–30; [CCPR/C/IRL/CO/4](#), para. 11; and [CEDAW/C/IRL/CO/6-7](#), para. 15 (a).

⁸⁶ [A/74/137](#), para. 24.

⁸⁷ See <https://maps.reproductiverights.org/worldabortionlaws>.

and regrets that three out of every four abortions in Africa and Latin America are unsafe, with up to 13.2 per cent of all maternal deaths attributable to unsafe abortion.⁸⁸ She is concerned that in some jurisdictions where abortion is criminalized, authorities employ mandatory reporting provisions to justify forcing practitioners to breach doctor-patient confidentiality, with very dangerous implications for the right to health as illustrated in the case of *Manuela y Otros v. El Salvador* before the Inter-American Court of Human Rights.⁸⁹

51. Under the Convention on the Elimination of All Forms of Discrimination against Women and general international law, States are also responsible for gender-based violence resulting from actions or omissions by its State actors, and by non-State actors. State responsibility for gender-based violence by state actors includes the obligation to prevent these acts and to investigate, prosecute and apply appropriate legal or disciplinary sanctions as well as to provide reparation. The State is responsible for acts or omissions by non-State actors attributable to the State, or for its failure to comply with its due diligence obligation to take all appropriate measures to prevent or investigate, prosecute, punish or provide reparation for such acts or omissions.⁹⁰

C. Violence perpetrated on or against children

52. The Special Rapporteur would like to echo the Committee on the Rights of the Child and emphasizes that no violence against children is justifiable and that all violence against children is preventable.⁹¹

53. Childhood is recognized as a protected period of time, until the age of 18 during which children must be allowed to grow, learn, play, develop and flourish with dignity⁹² and in a manner that is consistent with their evolving capacities.⁹³ During childhood, children's personal autonomy is developing, and hence their independence and participation must be respected.⁹⁴ Children are highly vulnerable to violence, putting their health and right to health at high risk.

54. According to WHO, violence against children has both short-term and lifelong health consequences. Violence may result in death, lead to severe injuries, and impair brain and nervous system development that may negatively affect cognitive development. Children exposed to violence adopt negative coping behaviours and are more likely to smoke and misuse alcohol and drugs. They also have higher rates of anxiety, depression, other mental health problems and suicide. They may drop out of school, have difficulty finding and keeping a job and are at greater risk of later victimization or perpetration of interpersonal or self-directed violence.⁹⁵

55. The Convention on the Rights of the Child, the most widely ratified human rights treaty in history, protects the rights of all children everywhere to be free from discrimination, violence and neglect. The Committee on the Rights of the Child understands violence as all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, as set out in article 19, paragraph 1, of the Convention. The Committee affirms the obligation of States to address and eliminate violence against children,⁹⁶ a commitment that is reinforced by the 2030 Agenda,⁹⁷ most explicitly in target 16.2.

⁸⁸ See WHO (2021), <https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion>.

⁸⁹ Inter-American Court of Human Rights, *Manuela y Otros v. El Salvador*, 2021.

⁹⁰ *Ibid.*, paras. 22–26.

⁹¹ Committee on the Rights of the Child, general comment No. 13 (2011), para. 3 (a).

⁹² Convention on the Rights of the Child, United Nations, *Treaty Series*, vol. 1577, No. 27531.

⁹³ *Ibid.*

⁹⁴ Gerison Lansdown, “The evolving capacities of the child”, *Innocenti Insights*, No. 11 (2005).

⁹⁵ See <https://www.who.int/news-room/fact-sheets/detail/violence-against-children#:~:text=Result%20in%20negative%20coping%20and,mental%20health%20problems%20and%20suicide>.

⁹⁶ Committee on the Rights of the Child, general comment 13 (2011), paras. 4 and 13.

⁹⁷ General Assembly resolution 70/1.

56. An estimated 140 million girls are missing as a result of the practice of gender-biased sex selection.⁹⁸ The global status report on preventing violence against children states that globally, it is estimated that one out of two children between 2 and 17 years of age experience some form of violence each year, that one out of three experiences emotional violence and that some 120 million girls are subjected to forced sexual contact before the age of 20.⁹⁹ In addition, the COVID-19 pandemic has impacted violence against children and led to an increase in calls to helplines about child abuse. Increased online sexual exploitation and cyberbullying have also been reported.¹⁰⁰

57. According to the United Nations Children’s Fund (UNICEF), more than 650 million women alive today were married as children, and more than a third of those unions took place before the women were 15. Concern regarding child marriage in humanitarian contexts has been increasing.¹⁰¹

58. Child marriage is prohibited under international law,¹⁰² and is a form of sexual and gender-based violence¹⁰³ that disproportionately affects girls, putting them at risk of sexual violence, although boys may also be victims of child marriage.¹⁰⁴ While the prevalence of child marriage has decreased worldwide – from one in four girls married a decade ago to approximately one in five today – the practice remains widespread¹⁰⁵ and occurs in all regions of the world. It has negative consequences for the enjoyment of the right to health, in particular sexual and reproductive health, and the right to education.

59. While intersex children, and later as adults, may face multiple problems, the most pressing for intersex children is the ongoing practice of intersex genital mutilation, which constitutes a significant human rights violation and must stop.

60. Female genital mutilation and cutting, which refers broadly to any procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons, is a harmful practice and another form of gender-based violence.¹⁰⁶ While much of the research on female genital mutilation and cutting has focused on practicing communities in Africa, it is also performed in Latin America, Asia and the Middle East.¹⁰⁷ Countries must also grapple with the prevalence of the practice in diaspora communities and the impacts on immigrant girls and women.¹⁰⁸ The practice of female genital mutilation and cutting undermines women’s and girls’ enjoyment of the right to the highest attainable standard of physical and mental health¹⁰⁹ and must be eliminated.

D. Conflict-related sexual violence

61. Building on its landmark resolution 1325 (2000) on “Women and peace and security”, the Security Council adopted resolutions 1820 (2008), 1888 (2009) and 1960 (2010), which address the issue of conflict-related sexual violence, requesting the Secretary-General to monitor and report to the Council to designate a Special Representative to lead inter-agency action against conflict-related sexual violence. Pursuant to the above-mentioned resolutions, the necessary structure to monitor, analyse and report on conflict-related sexual violence was

⁹⁸ Submission of UNFPA.

⁹⁹ <https://www.who.int/teams/social-determinants-of-health/violence-prevention/global-status-report-on-violence-against-children-2020>.

¹⁰⁰ Ibid.

¹⁰¹ See Human Rights Council resolution 35/16.

¹⁰² See [A/HRC/26/22](#), paras. 7–16; [A/73/257](#); and [A/71/253](#).

¹⁰³ Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women and general comment No. 18 of the Committee on the Rights of the Child on harmful practices (2019), paras. 7 and 8.

¹⁰⁴ C. Misunas, and others, “Child marriage among boys in high-prevalence countries: an analysis of sexual and reproductive health outcomes” *BMC International Health and Human Rights* (2019).

¹⁰⁵ Submission of UNFPA.

¹⁰⁶ <https://www.who.int/publications/i/item/9789241596442>, p. 4.

¹⁰⁷ Ibid., p. 1; and <https://www.who.int/en/news-room/fact-sheets/detail/female-genital-mutilation>.

¹⁰⁸ <https://www.who.int/publications/i/item/9789241596442>, p. 7.

¹⁰⁹ Ibid., p. 9.

established.¹¹⁰ The Council, in subsequent resolutions, enabled further conceptualization of the issue, placed this form of violence prominently on its agenda, and demanded action by peace, security, political, human rights, humanitarian and development actors.¹¹¹

62. In areas of conflict, conflict-related sexual violence is used as a tactic of war, torture and terrorism,¹¹² with violent actors weaponizing it to achieve a myriad of politically, socially and/or economically motivated ends.¹¹³

63. Conflict-related sexual violence has sweeping implications for the health of millions of people worldwide, especially, but not solely, women and girls.¹¹⁴ When territories become militarized through the presence of legal or illegal armed groups, the masculinity model is elevated, such that women and girls are further subjugated by both military and non-military personnel, resulting in greater barriers to equality, let alone the right to health.¹¹⁵

64. There is also a lack of information about the availability of sexual and reproductive health services for displaced populations outside of camp settings, for non-displaced populations during conflict or for cases of unreported need.¹¹⁶ States embroiled in conflict often have an insufficient number of qualified, trained health-care workers available to treat survivors of sexual violence.¹¹⁷

65. While power inequity and hostility between different ethnic and socioeconomic groups were not an invention of colonialism, coloniality has had a profound impact on the hierarchical social and political systems in post-colonial States around the world.¹¹⁸ Many conflict areas exist in a post-colonial context, as precolonial ethnic group organization worsened tensions between different ethnic groups in postcolonial, independent States.¹¹⁹ The impact of colonization on the political and social stability of those States must be incorporated into an analysis of their efforts to combat conflict-related sexual violence, and of their ability to institute an effective infrastructure to support survivors of sexual violence and prevent reoccurrence.¹²⁰

66. In his most recent report on conflict-related sexual violence, the Secretary-General reported on events that occurred in 2020, highlighting how the impacts of conflict globally were compounded by the COVID-19 pandemic. It documented sexual violence in Afghanistan, including acts of sexual violence against women, girls, and boys by the Taliban and the Afghan military and police; the Central African Republic, including increasing levels of violence following the presidential and legislative elections in December 2020; and acts of sexual violence in the Central African Republic, Colombia, the Democratic Republic of the Congo, Iraq, Libya, Mali, Myanmar, Somalia, South Sudan, the Sudan, the Syrian Arab Republic and Yemen.¹²¹

67. The Special Rapporteur welcomes the survivor-centred approach articulated by the Security Council in resolution 2467 (2019), and echoes the view of the Secretary-General that it requires the recognition that survivors are not a homogenous group and that they suffer differentiated harms based on intersecting inequalities, which can compound over time in the absence of a tailored response.¹²² In 2021, United Nations Action, a network of 19 United Nations entities working as one to end conflict-related sexual violence, developed a new strategic framework (2020–2025) focusing on a comprehensive and survivor-centred

¹¹⁰ <https://www.stoprabenow.org/wp-content/uploads/2021/11/UN-Action-Summary-Report-2009-%E2%80%932019-Milestones-and-Key-Achievements-1.pdf>.

¹¹¹ Security Council resolutions 2106 (2013), 2242 (2015), 2331 (2016) and 2467 (2019).

¹¹² S/2021/312, para 5.

¹¹³ Ibid, paras. 10–16.

¹¹⁴ http://apps.who.int/iris/bitstream/handle/10665/75179/WHO_RHR_HRP_12.18_eng.pdf?sequence=1.

¹¹⁵ See <https://www.ohchr.org/en/Issues/Women/WRGS/Pages/PeaceAndSecurity.aspx>.

¹¹⁶ M. Munyuzangabo, and others, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7375437/>.

¹¹⁷ A/HRC/47/28, para. 56.

¹¹⁸ Ibid., para. 9.

¹¹⁹ Jack Paine, *Ethnic Violence in Africa: Destructive Legacies of Pre-colonial States* (2019).

¹²⁰ Ibid.

¹²¹ S/2021/312 (2021).

¹²² S/2020/487 para 14.

approach, including prevention of conflict-related sexual violence by addressing its root causes.¹²³

E. Structural or institutionalized violence

68. Systemic or institutional violence refers to institutional practices, laws or procedures that adversely affect groups or individuals psychologically, mentally, culturally, economically, spiritually or physically. This type of violence has its origins within or outside the State, and is a major obstacle for the realization of the right to health.

69. Growing attention to human rights in situations of structural violence is welcome, and echoes the research and analysis on this topic in the health sector, and on families, education and schools developed in the decades since the term was coined in 1969 by Johan Galtung.¹²⁴ What Nancy Scheper-Hughes described as the little routines and enactments of violence normalized in State and social institutions have a severe accumulated impact on people's integrity and agency.¹²⁵ 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).¹²⁶ The violence inherent in social structures of racism, ableism, patriarchy and classism and their everyday operation is evident to anyone subjected to them.

70. Structural violence is a subtle and quite often invisible form of violence normalized through laws, policies and the institutionalization of certain practices¹²⁷ that have their roots in legacies of colonialism, racism, apartheid and structural socioeconomic inequalities.¹²⁸ It creates unjust barriers that are socially and systemically designed to marginalize individuals and populations across the race, class and gender divide, thereby limiting the realization of the right to health for many populations.¹²⁹ Structural violence with deep roots in patriarchal, hegemonic, and colonial definitions of society and social order is deeply entwined with sexual and gender-based violence and the denial of survivors' access to health care and medical services.¹³⁰ It includes denial of abortion, preventable maternal morbidity, the criminalization of sex work, State-sanctioned sterilization and State-sanctioned intersex genital mutilation.¹³¹ Such instances of structural violence are seen across both the global North and global South.

71. Structural violence, when suffered at the hands of law enforcement or while in custody, creates similar barriers to the right to the highest attainable standard of health. Globally, police brutality and impunity contribute to non-reporting of sexual and gender-based violence and the perpetuation of this kind of violence at the hands of officers and institutions of the law. Those issues arise particularly in contexts where abortion, same-sex relationships, transgender status or sex work are criminalized,¹³² or where gender-based violence is condoned. Criminalization enables abuse and exploitation. Sex workers are exposed to conditions that include exposure to sexually transmitted infections but also to

¹²³ See <https://stoprapenow.org/wp-content/uploads/2021/04/UN-Action-Strategic-Framework-2020-2025-2021.pdf>

¹²⁴ Johan Galtung, "Violence, peace and peace research", *Journal of Peace Research*, vol. 6, No. 3 (1969), pp. 167–191.

¹²⁵ S. Hamed, S. Thapar-Björkert, H. Bradby and B.M. Ahlberg, "Racism in European health care: structural violence and beyond", *Qualitative Health Research*, vol. 30, No. 11 (2020), <https://doi.org/10.1177/1049732320931430>, p. 1664.

¹²⁶ *Ibid.*, p.1,666.

¹²⁷ J.Z. Rucell, "Violence and colonial conditioning in South Africa's reproductive health system", PhD dissertation, University of Leeds, 2017.

¹²⁸ P. Farmer, "An anthropology of structural violence", *Current Anthropology* (2004), pp. 305–325.

¹²⁹ See J.Z. Rucell, 2017.

¹³⁰ A/HRC/17/26, para. 24; A/66/215, para. 83; and submission of Sexual Rights Initiative.

¹³¹ See submissions of Sexual Rights Initiative; Global Justice Centre; Organization Intersex International Europe; OutRight Action International; Women and Harm Reduction International; Human Rights Society of Maranhão (SMDH); and Validity.

¹³² Submissions of Belarusian Helsinki Committee; joint submission of Women's Legal Centre, Her Rights Initiative and Sexual Rights Initiative; and of Network of LGBTI Litigants of the Americas.

violence, extortion and intimidation by clients and police, nearly always without recourse. A South African study suggested that as many as 12 per cent of street-based sex workers in Cape Town had been raped by police officials.¹³³

72. In carceral settings such as prisons, immigration detention centres, and psychiatric hospitals or institutions, where people are deprived of their liberty over a period of time, the risks and exposure to violence are magnified. In settings of State control and imprisonment, conditions are often masculinized and heteronormative, serving women, gender and sexual minorities exceptionally poorly.¹³⁴ Case studies from Afghanistan, Honduras, Papua New Guinea, the Philippines, South Sudan and Tunisia suggest that a “survivor-centred justice” approach – with legal systems that are responsive to sexual violence with consequences for perpetrators and support for survivors, and that are transformative of harmful social norms – can significantly prevent the perpetration of domestic and gender-based violence.¹³⁵

73. Another element of structural violence, often overlooked, relates to space as a social product that is constructed on the basis of values and the social production of meanings.¹³⁶ Spaces and buildings can be racialized, gendered and sexualized in various ways to include some and exclude others. It is necessary to question the positionalities of the people involved in the making of spaces; the implication is that the beliefs and aspirations of such people become embedded in the construction of spaces, leaving us with typically wealthy, white, male, heterosexual, able-bodied spaces that serve the interests and comforts of an elite few.¹³⁷ The use of space has implications for the treatment of women, queer people, people with disabilities, and poor, Black and other marginalized people.

74. Spatial violence includes discriminatory spatial planning. Historical legislation in many countries where segregation was implemented dictated that marginalized people be placed far from city centres where wealthy, white citizens lived. The legacies thereof persist today, and often people have to commute over multiple days for medical services, adding to the cost of their care. These communities live where there is air, water and land pollution, and in high-density spaces, leading to poor ventilation. The resulting inequality in spatial planning and allocation is violence, yet it is positioned as circumstantial.

75. The discussion of space also ties into architecture, in that buildings are designed with the needs of those who design them in mind.¹³⁸ That phenomenon can be seen in the number of buildings that are not disability-friendly, do not cater to queer persons’ need for gender-neutral bathrooms, don’t accommodate children, do not cater to the needs of all people who menstruate, ignore elderly and frail people and exclude people experiencing homelessness. The preceding examples illustrate structural and social violence that not only places barriers in the way of people wanting to access services, but also denies people a sense of belonging in society.

F. Violence against health workers

76. On 3 May 2016, the Security Council adopted resolution 2286 (2016) on the protection of civilians in armed conflict and medical personnel. Following the adoption of the resolution, a five-year review by the Safeguarding Health in Conflict Coalition revealed 4,094 attacks against health care, including 681 health workers killed, 1,424 injured and 201 kidnapped. During the period, every two days a health worker was kidnapped or injured, and every three days a health worker was killed. The Special Rapporteur is concerned that attacks on medical facilities and personnel in protracted and recent conflicts continues. From the outset of the conflict in the Syrian Arab Republic in March 2011 until March 2022, Physicians for Human Rights documented the killing of 942 medical personnel.¹³⁹ Since the

¹³³ Joint submission of Women’s Legal Centre, Her Rights Initiative and Sexual Rights Initiative.

¹³⁴ Submission of Dignity.

¹³⁵ Submission of International Development Law Organization.

¹³⁶ Henri Lefebvre, *The Production of Space* (Blackwell, 1991).

¹³⁷ Nirmal Puwar, “The archi-texture of Parliament: flaneur as method in Westminster”, *The Journal of Legislative Studies*, vol. 16, No. 3 (2010), pp. 298–312.

¹³⁸ Ibid.

¹³⁹ <https://syriamap.phr.org/#/en>.

beginning of the war in Ukraine on 24 February 2022, WHO has registered 58 attacks against medical facilities, impacting 16 medical personnel. The Special Rapporteur also notes that in addition to conflict-related attacks, reports point to attacks on health-care workers related to the COVID-19 pandemic.¹⁴⁰

77. The Special Rapporteur underscores that the right to health includes the right to healthy occupational conditions. It is crucial that health-care workers' physical and mental health remain supported as they are key in the delivery of acceptable, accessible, affordable and quality care.

VI. Examples and good practices of health-related responses to violence

78. State replies to the questionnaire sent by the Special Rapporteur focused mainly on gender-based violence against women and girls, in particular domestic and sexual violence. States reported legal frameworks in place,¹⁴¹ and specific laws and strategies targeting, for example, violence against persons with disabilities¹⁴² and children;¹⁴³ violence against women drug users, including with a focus on Roma communities;¹⁴⁴ and violence against migrant and refugee women.¹⁴⁵ States also reported on their national plans or strategies¹⁴⁶ and specific budget lines,¹⁴⁷ and some shared national statistics.¹⁴⁸

79. Responses to survivors of gender-based violence against women and violence against children are multisectoral and often include coordinated referral mechanisms and special protocols for survivors of sexual violence.¹⁴⁹ State-led, health-related responses commonly fall under the ministry of health and are provided in primary health centres and other health facilities. Services include prevention, emergency confidential medical care depending on victims' needs, sharing information with the victim on available support services and referrals to other services as appropriate.¹⁵⁰ Some States also reported on the response to violence experienced by LGBTIQ+ persons,¹⁵¹ persons with disabilities¹⁵² and trans women, sex workers and trafficked women.¹⁵³ The training of health workers¹⁵⁴ and access to justice¹⁵⁵ were also reported as an essential part of multisectoral responses. Complementary services include State-led hotlines for counselling and psychological support to survivors, rapid assessment of needs, provision of shelter and emergency financial support.¹⁵⁶ Some States also reported ad hoc measures during COVID-19 such as increasing financial support to survivors of domestic violence.¹⁵⁷

80. Civil society actors emphasized the important role of community health workers in addressing the medical needs of survivors of violence, as well as the provision of immediate

¹⁴⁰ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31858-4/fulltext#coronavirus-linkback-header](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31858-4/fulltext#coronavirus-linkback-header).

¹⁴¹ See submissions of Albania, Australia, Ecuador, Greece, Ireland, Israel, Malta, Mauritius, the Philippines and Saudi Arabia. See also submissions of national human rights institutions in Albania, Argentina, Bosnia and Herzegovina, Ecuador, France, Georgia and Mexico; and of UNFPA and GIRE.

¹⁴² Submissions of Australia, Chile and Ireland.

¹⁴³ Submissions of Australia, Chile, Israel and Saudi Arabia.

¹⁴⁴ Submission of Croatia.

¹⁴⁵ Submission of Greece.

¹⁴⁶ Submissions of Albania, Australia and Ecuador.

¹⁴⁷ Submissions of Ecuador, Ireland, Sweden and United Kingdom of Great Britain and Northern Ireland.

¹⁴⁸ Submissions of Ecuador, Ireland, the Philippines and Sweden.

¹⁴⁹ Submissions of Albania, Malta, Mauritius and Sweden.

¹⁵⁰ Submissions of Albania and Ecuador.

¹⁵¹ Submission of Ecuador.

¹⁵² Ibid.

¹⁵³ Submission of Ireland.

¹⁵⁴ Submission of Albania.

¹⁵⁵ Submissions of Australia and Ecuador.

¹⁵⁶ Submissions of Albania and Israel.

¹⁵⁷ Submissions of Albania and Australia.

medical care to victims of sexual offences.¹⁵⁸ Other successful initiatives referred to civil society-led hotlines, psychological counselling, provision of shelters and safe spaces as well as legal aid.¹⁵⁹ In Belarus, the men's anonymous counselling initiative targeted men and combated gender stereotypes, until its closure owing to a lack of funding.¹⁶⁰ Telecounselling and mobile health proved helpful in providing information on sexual and reproductive health, including access to abortion, during the pandemic and support for LGBTIQ+ victims of violence (for example, the Nazariya Indian helpline).¹⁶¹ Other positive examples included 24/7 peer community support, trained crisis service counsellors and support resources for LGBTIQ+ youth.¹⁶²

81. The United Nations Population Fund (UNFPA) reported good practices supporting State actors (including ministries of health) in developing comprehensive services for survivors of gender-based violence in development and humanitarian contexts.¹⁶³ Other stakeholders reported successful initiatives to help report gender-based violence, such as *Visible*, the first online platform for reporting violence and discrimination against LGBTIQ+ persons in Mexico.¹⁶⁴

82. A good example of violence prevention through education is the landmark decision of the Inter-American Court of Human Rights in Guzmán, *Albarracin et al v. Ecuador*, in which the Court recognized sex education as a fundamental right and a way to prevent violence, in particular against girls, and related health consequences.¹⁶⁵ UNFPA also reported good examples integrating prevention of gender-based violence into State-led comprehensive sexuality education.¹⁶⁶

83. Other successful initiatives referred to support to sex workers and trafficked persons in filing official complaints, and comprehensive care ranging from access to prevention of HIV and STIs to testing, linkages to public hospitals and centres for infectious diseases, and hormonal therapy and psychological counselling.¹⁶⁷ Safe spaces for drug users and survivors of violence proved critical in Spain and the United Republic of Tanzania.¹⁶⁸

84. In Mongolia an initiative focused on the provision of legal and other services to child victims of violence during COVID-19, while in Tunisia support focused on the economic participation of survivors of violence.¹⁶⁹ In Malawi a one-stop centre for gender-based violence, located inside a hospital, ensures access to women and girls with disabilities. In Tajikistan a joint effort by the Ministry of Health and UNFPA enabled sexual and reproductive health care and psychosocial support related to gender-based violence, for women with disabilities.¹⁷⁰ In Spain a project focused on women and girls with intellectual disabilities to provide a forum for learning and discussion on sexual and reproductive health rights.¹⁷¹

85. Submissions emphasized the importance of ensuring victim-friendly rooms for victims of domestic and sexual violence; a useful example is the Public Prosecutor's Office of the Argentine Republic that created the Specialized Prosecutor's Unit on Violence against Women, which has, among its legal abilities, the mandate to intervene in cases of gender-based violence against women and LGBTIQ+ people.¹⁷²

¹⁵⁸ Joint submission of Women's Legal Centre, Her Rights Initiative and Sexual Rights Initiative.

¹⁵⁹ Submission of Centre for Applied Legal Studies, University of the Witwatersrand, South Africa.

¹⁶⁰ Submission of Belarus Helsinki Committee.

¹⁶¹ Submission of Choice.

¹⁶² Ibid.

¹⁶³ Submission of UNFPA.

¹⁶⁴ Submission of Amicus.

¹⁶⁵ Submission of Centre for Reproductive Rights.

¹⁶⁶ Submission of UNFPA.

¹⁶⁷ Submission of European Sex Workers Rights Alliance.

¹⁶⁸ Submission of International Network of People Who Use Drugs.

¹⁶⁹ Submission of International Development Law Organization.

¹⁷⁰ Joint submission of gender and disability organizations.

¹⁷¹ Ibid.

¹⁷² Joint submission of Women's Legal Centre, Her Rights Initiative and Sexual Rights Initiative.

VII. Conclusions and recommendations

86. The Special Rapporteur underlines the importance of adopting a non-binary approach to gender and gender-based violence under the right to health.

87. A comprehensive health response to violence should look at the nature and extent of the harm caused by types of violence, should take into consideration the context (that is, conflict, displacement), location (rural, urban) and personal characteristics of the survivor (sex, gender identity, disability, race, ethnicity, age) and should take into account the intersecting forms of discrimination that exacerbate the impact of violence on the survivors' enjoyment of the right to health.

88. To achieve a comprehensive health response to violence, it is necessary to adopt an inclusive and non-binary approach to gender and gender-based violence, and must ensure that all laws, policies, programmes and services addressing gender-based violence are inclusive of all persons, with or without disabilities, children and adults, and should include cisgender, transgender, non-binary, queer and intersex people.

89. There is no single health approach to support or respond to survivors of violence. Violence should be defined in the broadest terms so as to include as many affected people as possible and should include structural violence as well. Furthermore, a right-to-health based response to victims of violence must ensure confidentiality and refrain from hierarchies between forms of violence, between survivors and harms caused.

90. Health interventions should be framed within a comprehensive multisectoral response addressing the holistic needs of survivors of violence and their families, including the referral to specialized services and multisectoral services, including financial and legal support, safe accommodation, and accountability and redress. The aim should be to prevent the occurrence of violence in the first place and provide immediate, mid- and long-term support, with a view to mitigating the consequences of violence and associated health-related consequences.

91. Survivors of violence, including sexual violence, are entitled under the right to health to access the necessary health care (such as psychological support, emergency post-rape care, medico-legal assistance), services, goods and facilities, including sexual and reproductive health services, which play an important role in ensuring redress.¹⁷³ Trained and supported professionals who work in a healthy environment free from violence are the backbone.

92. The Special Rapporteur agrees with the recommendation of the Secretary-General to the Security Council to streamline into all relevant country-specific resolutions, mandate authorizations and renewals of peacekeeping operations and special political missions, provisions to strengthen the monitoring, analysis and reporting arrangements on conflict-related sexual violence and grave violations against children, and allocate sufficient human and financial resources, including through the deployment of specialized and dedicated expertise.¹⁷⁴

93. The operationalization of the right-to-health approach requires a focus on national, regional and international legal frameworks, the strengthening of health systems, data and reporting, clinical response and prevention. It is also important to focus on the resourcing and financing of comprehensive solutions centred around the restoration of dignity of all people, achieved when decisions include meaningful participation of communities and local feminist movements. Third-party financiers must not place conditions on grantees such as pledges against other human rights.

94. The Special Rapporteur recalls that State parties' immediate obligations include guarantees of non-discrimination and equal treatment and the obligation to take deliberate, such targeted steps towards the full realization of the right to health as the preparation of a national public health strategy and plan of action. Progressive

¹⁷³ United Nations Mission in South Sudan and OHCHR, "Access to health for survivors of conflict-related sexual violence in South Sudan", May 2020, para. 10.

¹⁷⁴ [S/2022/77](#).

realization means that States have a specific and continuing obligation to move as expeditiously as possible towards the full realization of the right to health.¹⁷⁵

95. The Sustainable Development Goals can be instrumental in the holistic realization of the right to health, if human rights are effectively incorporated in their implementation. At this point, it is necessary to reflect on how prevailing violence has diminished the ability of individuals, communities and nations to realize the goals and ultimately will lead to a catastrophic failure to meet the targets of the 2030 agenda.

96. An intersectional and rights-based approach to violence that addresses the root causes of such violence, including the binary conceptualization of gender and heteronormative norms, and patriarchal, racist, ableist and capitalist oppression and determinants of health in law and practice, is urgently needed.

97. To reach the goal of substantive equality it is essential to start with what it takes for the most vulnerable among us to thrive.

98. The Special Rapporteur underscores the right of all people to be free from violence and agrees with Toni Morrison: “You are moving in the direction of freedom, and the function of freedom is to free somebody else”.¹⁷⁶

¹⁷⁵ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000).

¹⁷⁶ See <https://zora.medium.com/toni-morrison-in-her-own-words-562b14e0effa>.