



General Assembly

Distr.: General
1 February 2013

Original: English

Human Rights Council

Twenty-second session

Agenda item 3

**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development**

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez

Summary

The present report focuses on certain forms of abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment. It identifies the policies that promote these practices and existing protection gaps.

By illustrating some of these abusive practices in health-care settings, the report sheds light on often undetected forms of abusive practices that occur under the auspices of health-care policies, and emphasizes how certain treatments run afoul of the prohibition on torture and ill-treatment. It identifies the scope of State's obligations to regulate, control and supervise health-care practices with a view to preventing mistreatment under any pretext.

The Special Rapporteur examines a number of the abusive practices commonly reported in health-care settings and describes how the torture and ill-treatment framework applies in this context. The examples of torture and ill-treatment in health settings discussed likely represent a small fraction of this global problem.

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I. Introduction

1. The present report is submitted to the Human Rights Council in accordance with Council resolution 16/23.
2. Reports of country visits to Tajikistan and Morocco are contained in documents A/HRC/22/53/Add.1 and Add.2, respectively. A/HRC/22/53/Add.3 contains an update on follow-up measures and A/HRC/22/53/Add.4 contains observations made by the Special Rapporteur on some of the cases reflected in the communication reports A/HRC/20/30, A/HRC/21/49 and A/HRC/22/67.

II. Activities of the Special Rapporteur

A. Upcoming country visits and pending requests

3. The Special Rapporteur plans to visit Bahrain in May 2013 and Guatemala in the second half of 2013 and is engaged with the respective Governments to find mutually agreeable dates. The Special Rapporteur has accepted an invitation to visit Thailand in February 2014. He also notes with appreciation an outstanding invitation to visit Iraq.
4. The Special Rapporteur has reiterated his interest to conduct country visits to a number of States where there are pending requests for invitations: Cuba; Ethiopia; Ghana; Kenya; United States of America; Uzbekistan; Venezuela (Bolivarian Republic of) and Zimbabwe. The Special Rapporteur has also recently requested to visit Chad, Côte d'Ivoire, Dominican Republic, Georgia, Mexico and Viet Nam.

B. Highlights of key presentations and consultations

5. On 10 September 2012, the Special Rapporteur participated in a Chatham House event in London hosted by REDRESS on "Enforcing the absolute prohibition against torture".
6. On 26 September 2012, the Special Rapporteur met the Director General of the National Human Rights Commission of the Republic of Korea, who was visiting Washington D.C.
7. Between 22 and 24 October 2012, the Special Rapporteur presented his interim report (A/67/279) to the General Assembly and participated in two side events: one, held at the Permanent Mission of Denmark to the United Nations in New York, on "Reprisals against victims of torture and other ill-treatment" and the other organized jointly with the World Organisation Against Torture, Penal Reform International, the Centre for Constitutional Rights and Human Rights Watch on "The death penalty and human rights: the way forward". He also met with representatives of the Permanent Missions of Guatemala and Uruguay.
8. On 17 November 2012, the Special Rapporteur participated in a symposium organized by New York University on the practice of solitary confinement, entitled "Solitary: wry fancies and stark realities".
9. From 2 to 6 December 2012, the Special Rapporteur conducted a follow-up visit to Uruguay (A/HRC/22/53/Add.3), at the invitation of the Government, to assess improvements and identify remaining challenges regarding torture and other cruel, inhuman or degrading treatment or punishment.

10. From 13 to 14 December 2012, the Special Rapporteur convened an expert meeting on “Torture and ill-treatment in healthcare settings” at the Center for Human Rights and Humanitarian Law, American University in Washington, DC.

III. Applying the torture and ill-treatment protection framework in health-care settings

11. Mistreatment in health-care settings¹ has received little specific attention by the mandate of the Special Rapporteur, as the denial of health-care has often been understood as essentially interfering with the “right to health”.

12. While different aspects of torture and ill-treatment in health-care settings have been previously explored by the rapporteurship and other United Nations mechanisms, the Special Rapporteur feels that there is a need to highlight the specific dimension and intensity of the problem, which often goes undetected; identify abuses that exceed the scope of violations of the right to health and could amount to torture and ill-treatment; and strengthen accountability and redress mechanisms.

13. The Special Rapporteur recognizes that there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on grounds of administrative efficiency, behaviour modification or medical necessity. The intention of the present report is to analyse all forms of mistreatment premised on or attempted to be justified on the basis of health-care policies, under the common rubric of their purported justification as “health-care treatment”, and to find cross-cutting issues that apply to all or most of these practices.

A. Evolving interpretation of the definition of torture and ill-treatment

14. Both the European Court of Human Rights (ECHR) and the Inter-American Court of Human Rights have stated that the definition of torture is subject to ongoing reassessment in light of present-day conditions and the changing values of democratic societies.²

15. The conceptualization of abuses in health-care settings as torture or ill-treatment is a relatively recent phenomenon. In the present section, the Special Rapporteur embraces this ongoing paradigm shift, which increasingly encompasses various forms of abuse in health-care settings within the discourse on torture. He demonstrates that, while the prohibition of torture may have originally applied primarily in the context of interrogation, punishment or intimidation of a detainee, the international community has begun to recognize that torture may also occur in other contexts.

16. The analysis of abuse in health-care settings through the lens of torture and ill-treatment is based on the definition of these violations provided by the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its authoritative interpretations. In order to demonstrate how abusive practices in health-care

¹ Health-care settings refers to hospitals, public and private clinics, hospices and institutions where health-care is delivered.

² World Organization Against Torture (OMCT), *The Prohibition of Torture and Ill-treatment in the Inter-American Human Rights System: A Handbook for Victims and Their Advocates* (2006), p. 107, citing Inter-American Court of Human Rights, *Cantoral-Benavides v. Peru*, Series C, No. 69 (2000) para. 99; ECHR, *Selmouni v. France*, Application No. 25803/94 (1999), para. 101.

settings meet the definition of torture, the following section provides an overview of the main elements of the definition of torture.

B. Applicability of the torture and ill-treatment framework in health-care settings

1. Overview of key elements of the definition of torture and ill-treatment

17. At least four essential elements are reflected in the definition of torture provided in article 1, paragraph 1, of the Convention against Torture: an act inflicting severe pain or suffering, whether physical or mental; the element of intent; the specific purpose; and the involvement of a State official, at least by acquiescence (A/HRC/13/39/Add.5, para. 30). Acts falling short of this definition may constitute cruel, inhuman or degrading treatment or punishment under article 16 of the Convention (A/63/175, para. 46). The previous Special Rapporteurs have covered in great detail the main components of the definition of torture. Nevertheless, there are a few salient points worth elaborating for the purpose of the present report.

18. The jurisprudence and authoritative interpretations of international human rights bodies provide useful guidance on how the four criteria of the definition of torture apply in the context of health-care settings. ECHR has noted that a violation of article 3 may occur where the purpose or intention of the State's action or inaction was not to degrade, humiliate or punish the victim, but where this nevertheless was the result.³

19. The application of the criteria of severe pain or suffering, intent, and involvement of a public official or other person acting in an official capacity, by consent or acquiescence to abuses in health-care settings, is relatively straightforward. The criterion of the specific purpose warrants some analysis.⁴

20. The mandate has stated previously that intent, required in article 1 of the Convention, can be effectively implied where a person has been discriminated against on the basis of disability. This is particularly relevant in the context of medical treatment, where serious violations and discrimination against persons with disabilities may be defended as "well intended" on the part of health-care professionals. Purely negligent conduct lacks the intent required under article 1, but may constitute ill-treatment if it leads to severe pain and suffering (A/63/175, para. 49).

21. Furthermore, article 1 explicitly names several purposes for which torture can be inflicted: extraction of a confession; obtaining information from a victim or a third person; punishment, intimidation and coercion; and discrimination. However, there is a general acceptance that these stated purposes are only of an indicative nature and not exhaustive. At the same time, only purposes which have "something in common with the purposes expressly listed" are sufficient (A/HRC/13/39/Add.5, para. 35).

22. Although it may be challenging to satisfy the required purpose of discrimination in some cases, as most likely it will be claimed that the treatment is intended to benefit the "patient", this may be met in a number of ways.⁵ Specifically, the description of abuses

³ See *Peers v. Greece*, Application No. 28524/95 (2001), paras. 68, 74; *Groni v. Albania*, Application No. 25336/04 (2009), para. 125.

⁴ Open Society Foundations, *Treatment or Torture? Applying International Human Rights Standards to Drug Detention Centers* (2011), p. 10.

⁵ *Ibid.*, p. 12.

outlined below demonstrates that the explicit or implicit aim of inflicting punishment, or the objective of intimidation, often exist alongside ostensibly therapeutic aims.

2. The scope of State core obligations under the prohibition of torture and ill-treatment

23. The Committee against Torture interprets State obligations to prevent torture as indivisible, interrelated, and interdependent with the obligation to prevent cruel, inhuman, or degrading treatment or punishment (ill-treatment) because “conditions that give rise to ill-treatment frequently facilitate torture”.⁶ It has established that “each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm”.⁷

24. Indeed, the State’s obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres (A/63/175, para. 51). As underlined by the Committee against Torture, the prohibition of torture must be enforced in all types of institutions and States must exercise due diligence to prevent, investigate, prosecute and punish violations by non-State officials or private actors.⁸

25. In *da Silva Pimentel v. Brazil*, the Committee on the Elimination of Discrimination against Women observed that “the State is directly responsible for the action of private institutions when it outsources its medical services” and “always maintains the duty to regulate and monitor private health-care institutions”.⁹ The Inter-American Court of Human Rights addressed State responsibility for actions of private actors in the context of health-care delivery in *Ximenes Lopes v. Brazil*.¹⁰

26. Ensuring special protection of minority and marginalized groups and individuals is a critical component of the obligation to prevent torture and ill-treatment. Both the Committee against Torture and the Inter-American Court of Human Rights have confirmed that States have a heightened obligation to protect vulnerable and/or marginalized individuals from torture, as such individuals are generally more at risk of experiencing torture and ill-treatment.¹¹

C. Interpretative and guiding principles

1. Legal capacity and informed consent

27. In all legal systems, capacity is a condition assigned to agents that exercise free will and choice and whose actions are attributed legal effects. Capacity is a rebuttable

⁶ General comment No. 2 (2007), para. 3.

⁷ *Ibid.*, para. 15.

⁸ General comment No. 2, paras. 15, 17 and 18. See also Committee against Torture, communication No. 161/2000, *Dzemajl et al. v. Serbia and Montenegro*, para. 9.2; Human Rights Committee, general comment No. 20 (1992), para. 2.

⁹ Communication No. 17/2008, para. 7.5.

¹⁰ Inter-American Court of Human Rights. (Series C) No. 149 (2006), paras. 103, 150; see also Committee on the Elimination of Discrimination against Women, general recommendation No. 19 (1992), para. 9.

¹¹ Committee against Torture, general comment No. 2, para. 21; *Ximenes Lopes v. Brazil*, para. 103.

presumption; therefore, “incapacity” has to be proven before a person can be designated as incapable of making decisions. Once a determination of incapacity is made, the person’s expressed choices cease to be treated meaningfully. One of the core principles of the Convention on the Rights of Persons with Disabilities is “respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons” (art. 3 (a)). The Committee on the Rights of Persons with Disabilities has interpreted the core requirement of article 12 to be the replacement of substituted decision-making regimes by supported decision-making, which respects the person’s autonomy, will and preferences.¹²

28. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health observed that informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision. Guaranteeing informed consent is a fundamental feature of respecting an individual’s autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services (A/64/272, para. 18).

29. As the Special Rapporteur on the right to health observed, while informed consent is commonly enshrined in the legal framework at the national level, it is frequently compromised in the health-care setting. Structural inequalities, such as the power imbalance between doctors and patients, exacerbated by stigma and discrimination, result in individuals from certain groups being disproportionately vulnerable to having informed consent compromised (*ibid.*, para. 92).

30. The intimate link between forced medical interventions based on discrimination and the deprivation of legal capacity has been emphasized both by the Committee on the Rights of Persons with Disabilities and the previous Special Rapporteur on the question of torture.¹³

2. Powerlessness and the doctrine of “medical necessity”

31. Patients in health-care settings are reliant on health-care workers who provide them services. As the previous Special Rapporteur stated: “Torture, as the most serious violation of the human right to personal integrity and dignity, presupposes a situation of powerlessness, whereby the victim is under the total control of another person.”¹⁴ Deprivation of legal capacity, when a person’s exercise of decision-making is taken away and given to others, is one such circumstance, along with deprivation of liberty in prisons or other places (A/63/175, para. 50).

32. The mandate has recognized that medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned (*ibid.*, paras. 40, 47). This is particularly the case when intrusive and irreversible, non-consensual treatments are performed on patients from marginalized groups, such as persons with disabilities, notwithstanding claims of good intentions or medical necessity. For example, the mandate has held that the discriminatory character of forced psychiatric interventions, when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of “good intentions” by medical professionals (*ibid.*, paras. 47, 48). In other examples, the administration of non-consensual medication or involuntary

¹² See CRPD/C/ESP/CO/1.

¹³ Convention on the Rights of Persons with Disabilities, art. 25 (d); see also CRPD/C/CHN/CO/1 and Corr.1, para. 38; A/63/175, paras. 47, 74.

¹⁴ A/63/175, para. 50.

sterilization is often claimed as being a necessary treatment for the so-called best interest of the person concerned.

33. However, in response to reports of sterilizations of women in 2011, the International Federation of Gynecology and Obstetrics emphasized that “sterilization for prevention of future pregnancy cannot be ethically justified on grounds of medical emergency. Even if a future pregnancy may endanger a woman’s life or health, she ... must be given the time and support she needs to consider her choice. Her informed decision must be respected, even if it is considered liable to be harmful to her health.”¹⁵

34. In those cases, dubious grounds of medical necessity were used to justify intrusive and irreversible procedures performed on patients without full free and informed consent. In this light, it is therefore appropriate to question the doctrine of “medical necessity” established by the ECHR in the case of *Herczegfalvy v. Austria* (1992),¹⁶ where the Court held that continuously sedating and administering forcible feeding to a patient who was physically restrained by being tied to a bed for a period of two weeks was nonetheless consistent with article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms because the treatment in question was medically necessary and in line with accepted psychiatric practice at that time.

35. The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings. It is therefore important to clarify that treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine.

3. Stigmatized identities

36. In a 2011 report (A/HRC/19/41), the United Nations High Commissioner for Human Rights examined discriminatory laws and practices and acts of violence against individuals based on sexual orientation and gender identity in health-care settings. She observed that a pattern of human rights violations emerged that demanded a response. With the adoption in June 2011 of resolution 17/19, the Human Rights Council formally expressed its “grave concern” regarding violence and discrimination based on sexual orientation and gender identity.

37. Many policies and practices that lead to abuse in health-care settings are due to discrimination targeted at persons who are marginalized. Discrimination plays a prominent role in an analysis of reproductive rights violations as forms of torture or ill-treatment because sex and gender bias commonly underlie such violations. The mandate has stated, with regard to a gender-sensitive definition of torture, that the purpose element is always fulfilled when it comes to gender-specific violence against women, in that such violence is inherently discriminatory and one of the possible purposes enumerated in the Convention is discrimination (A/HRC/7/3, para. 68).

38. In the context of prioritizing informed consent as a critical element of a voluntary counselling, testing and treatment continuum, the Special Rapporteur on the right to health has also observed that special attention should be paid to vulnerable groups. Principles 17 and 18 of the Yogyakarta Principles, for instance, highlight the importance of safeguarding informed consent of sexual minorities. Health-care providers must be cognizant of, and adapt to, the specific needs of lesbian, gay, bisexual, transgender and intersex persons (A/64/272, para. 46). The Committee on Economic, Social and Cultural Rights has

¹⁵ *Ethical Issues in Obstetrics and Gynecology* (2012), pp. 123–124.

¹⁶ Application No. 10533/83, paras. 27, 83.

indicated that the International Covenant on Economic, Social and Cultural Rights proscribes any discrimination in access to health-care and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of sexual orientation and gender identity.¹⁷

IV. Emerging recognition of different forms of abuses in health-care settings

39. Numerous reports have documented a wide range of abuses against patients and individuals under medical supervision. Health providers allegedly withhold care or perform treatments that intentionally or negligently inflict severe pain or suffering for no legitimate medical purpose. Medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment, and if there is State involvement and specific intent, it is torture.

A. Compulsory detention for medical conditions

40. Compulsory detention for drug users is common in so-called rehabilitation centres. Sometimes referred to as drug treatment centres or “reeducation through labor” centres or camps, these are institutions commonly run by military or paramilitary, police or security forces, or private companies. Persons who use, or are suspected of using, drugs and who do not voluntarily opt for drug treatment and rehabilitation are confined in such centres and compelled to undergo diverse interventions.¹⁸ In some countries, a wide range of other marginalized groups, including street children, persons with psychosocial disabilities, sex workers, homeless individuals and tuberculosis patients, are reportedly detained in these centres.¹⁹

41. Numerous reports document that users of illicit drugs who are detained in such centres undergo painful withdrawal from drug dependence without medical assistance, administration of unknown or experimental medications, State-sanctioned beatings, caning or whipping, forced labour, sexual abuse and intentional humiliation.²⁰ Other reported abuses included “flogging therapy”, “bread and water therapy”, and electroshock resulting in seizures, all in the guise of rehabilitation. In such settings, medical professionals trained to manage drug dependence disorders as medical illnesses²¹ are often unavailable.

42. Compulsory treatment programmes that consist primarily of physical disciplinary exercises, often including military-style drills, disregard medical evidence (A/65/255, paras. 31, 34). According to the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC), “neither detention nor forced labour have been recognized by science as treatment for drug use disorders”.²² Such detention – frequently

¹⁷ General comment No. 14 (2000), para. 18.

¹⁸ See World Health Organization (WHO), *Assessment of Compulsory Treatment of People Who Use Drugs in Cambodia, China, Malaysia and Viet Nam* (2009).

¹⁹ Human Rights Watch (HRW), *Torture in the Name of Treatment: Human Rights Abuses in Vietnam, China, Cambodia, and LAO PDR* (2012), p. 4.

²⁰ See Daniel Wolfe and Roxanne Saucier, “In rehabilitation’s name? Ending institutionalized cruelty and degrading treatment of people who use drugs”, *International Journal of Drug Policy*, vol. 21, No. 3 (2010), pp. 145-148.

²¹ United Nations Office on Drugs and Crime (UNODC) and WHO, “Principles of drug dependence treatment”, discussion paper, 2008.

²² *Ibid.*, p. 15.

without medical evaluation, judicial review or right of appeal – offers no evidence-based²³ or effective treatment. Detention and forced labour programmes therefore violate international human rights law and are illegitimate substitutes for evidence-based measures, such as substitution therapy, psychological interventions and other forms of treatment given with full, informed consent (A/65/255, para. 31). The evidence shows that this arbitrary and unjustified detention is frequently accompanied by – and is the setting for – egregious physical and mental abuse.

Overview of developments to date

43. The numerous calls by various international and regional organizations to close compulsory drug detention centres,²⁴ as well as the numerous injunctions and recommendations contained in the recently released guidelines by WHO on pharmacotherapy for opiate dependence,²⁵ the UNODC policy guidance on the organization's human rights responsibilities in drug detention centres,²⁶ and resolutions by the Commission on Narcotic Drugs,²⁷ are routinely ignored.²⁸ These centres continue to operate often with direct or indirect support and assistance from international donors without any adequate human rights oversight.²⁹

44. Notwithstanding the commitment to scale-up methadone treatment and evidence-based treatment as opposed to punitive approaches, those remanded to compulsory treatment in the punitive drug-free centres continue to exceed, exponentially, the number receiving evidence-based treatment for drug dependence.³⁰

B. Reproductive rights violations

45. The Special Rapporteur has, on numerous occasions, responded to various initiatives in the area of gender mainstreaming and combating violence against women, by, inter alia, examining gender-specific forms of torture with a view to ensure that the torture protection framework is applied in a gender-inclusive manner.³¹ The Special Rapporteur seeks to complement these efforts by identifying the reproductive rights practices in health-care settings that he believes amount to torture or ill-treatment.

46. International and regional human rights bodies have begun to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender.³² Examples of such violations include abusive treatment and humiliation in institutional settings;³³

²³ See for example WHO, UNODC, UNAIDS, *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (WHO, 2009).

²⁴ World Medical Association, "Call for compulsory drug Detention centers to be closed", press statement, 17 May 2011; United Nations entities, "Compulsory drug detention and rehabilitation centres", joint statement, March 2012.

²⁵ See Wolfe and Saucier, "In rehabilitation's name".

²⁶ "UNODC and the promotion and protection of human rights", position paper, 2012, p. 8.

²⁷ Such as resolutions 55/12 (2012); 55/2 (2012) and 55/10 (2012).

²⁸ See Wolfe and Saucier, "In rehabilitation's name".

²⁹ HRW, submission to the Special Rapporteur on the question of torture, 2012.

³⁰ See Wolfe and Saucier, "In rehabilitation's name".

³¹ See A/54/426, A/55/290.

³² CAT/C/CR/32/5, para. 7 (m); Human Rights Committee general comment No. 28 (2000), para. 11.

³³ See Center for Reproductive Rights, *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis* (2011).

involuntary sterilization; denial of legally available health services³⁴ such as abortion and post-abortion care; forced abortions and sterilizations;³⁵ female genital mutilation;³⁶ violations of medical secrecy and confidentiality in health-care settings, such as denunciations of women by medical personnel when evidence of illegal abortion is found; and the practice of attempting to obtain confessions as a condition of potentially life-saving medical treatment after abortion.³⁷

47. In the case of *R.R. v. Poland*, for instance, ECHR found a violation of article 3 in the case of a woman who was denied access to prenatal genetic testing when an ultrasound revealed a potential foetal abnormality. The Court recognized “that the applicant was in a situation of great vulnerability”³⁸ and that R.R.’s access to genetic testing was “marred by procrastination, confusion and lack of proper counselling and information given to the applicant”.³⁹ Access to information about reproductive health is imperative to a woman’s ability to exercise reproductive autonomy, and the rights to health and to physical integrity.

48. Some women may experience multiple forms of discrimination on the basis of their sex and other status or identity. Targeting ethnic and racial minorities, women from marginalized communities⁴⁰ and women with disabilities⁴¹ for involuntary sterilization⁴² because of discriminatory notions that they are “unfit” to bear children⁴³ is an increasingly global problem. Forced sterilization is an act of violence,⁴⁴ a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.⁴⁵ The mandate has asserted that “forced abortions or sterilizations carried out by State officials in accordance with coercive family planning laws or policies may amount to torture”.⁴⁶

49. For many rape survivors, access to a safe abortion procedure is made virtually impossible by a maze of administrative hurdles, and by official negligence and obstruction. In the landmark decision of *K.N.L.H. v. Peru*, the Human Rights Committee deemed the denial of a therapeutic abortion a violation of the individual’s right to be free from ill-treatment.⁴⁷ In the case of *P. and S. v. Poland*, ECHR stated that “the general stigma attached to abortion and to sexual violence ..., caus[ed] much distress and suffering, both physically and mentally”.⁴⁸

50. The Committee against Torture has repeatedly expressed concerns about restrictions on access to abortion and about absolute bans on abortion as violating the prohibition of torture and ill-treatment.⁴⁹ On numerous occasions United Nations bodies have expressed

³⁴ See CAT/C/PER/CO/4, para. 23.

³⁵ E/CN.4/2005/51, paras. 9, 12.

³⁶ A/HRC/7/3, paras. 50, 51, 53; CAT/C/IDN/CO/2, para. 16.

³⁷ CAT/C/CR/32/5, para. 6 (j).

³⁸ ECHR, *R.R. v. Poland*, Application No. 27617/04 (2011), para. 159.

³⁹ *Ibid.*, para. 153.

⁴⁰ See ECHR, *V.C. v. Slovakia*, Application No. 18968/07 (2011).

⁴¹ A/67/227, para. 28; A/HRC/7/3, para. 38.

⁴² A/64/272, para. 55.

⁴³ See Open Society Foundations, *Against Her Will: Forced and Coerced Sterilization of Women Worldwide* (2011).

⁴⁴ See Committee on the Elimination of Discrimination against Women, general recommendation No. 19, para. 22; Human Rights Committee, general comment No. 28, paras. 11, 20.

⁴⁵ A/HRC/7/3, paras. 38, 39.

⁴⁶ *Ibid.*, para. 69.

⁴⁷ Communication No. 1153/2003 (2005), para. 6.3.

⁴⁸ ECHR, Application No. 57375/08 (2012), para. 76.

⁴⁹ See CAT/C/PER/CO/4, para. 23.

concern about the denial of or conditional access to post-abortion care.⁵⁰ often for the impermissible purposes of punishment or to elicit confession.⁵¹ The Human Rights Committee explicitly stated that breaches of article 7 of the International Covenant on Civil and Political Rights include forced abortion, as well as denial of access to safe abortions to women who have become pregnant as a result of rape⁵² and raised concerns about obstacles to abortion where it is legal.

C. Denial of pain treatment

51. In 2012, WHO estimated that 5.5 billion people live in countries with low or no access to controlled medicines and have no or insufficient access to treatment for moderate to severe pain.⁵³ Despite the repeated reminders made by the Commission on Narcotic Drugs to States of their obligations,⁵⁴ 83 per cent of the world population has either no or inadequate access to treatment for moderate to severe pain. Tens of millions of people, including around 5.5 million terminal cancer patients and 1 million end-stage HIV/AIDS patients, suffer from moderate to severe pain each year without treatment.⁵⁵

52. Many countries fail to make adequate arrangements for the supply of these medications.⁵⁶ Low- and middle-income countries account for 6 per cent of morphine use worldwide while having about half of all cancer patients and 95 per cent of all new HIV infections.⁵⁷ Thirty-two countries in Africa have almost no morphine available at all.⁵⁸ In the United States, over a third of patients are not adequately treated for pain.⁵⁹ In France, a study found that doctors underestimated pain in over half of their AIDS patients.⁶⁰ In India, more than half of the country's regional cancer centres do not have morphine or doctors trained in using it. This is despite the fact that 70 per cent or more of their patients have advanced cancer and are likely to require pain treatment.⁶¹

53. Although relatively inexpensive and highly effective medications such as morphine and other narcotic drugs have proven essential “for the relief of pain and suffering”⁶², these types of medications are virtually unavailable in more than 150 countries.⁶³ Obstacles that unnecessarily impede access to morphine and adversely affect its availability include overly restrictive drug control regulations⁶⁴ and, more frequently, misinterpretation of otherwise appropriate regulations;⁶⁵ deficiency in drug supply management; inadequate infrastructure;⁶⁶ lack of prioritization of palliative care⁶⁷; ingrained prejudices about using

⁵⁰ See CAT/C/CR/32/5, para. 7 (m); A/66/254, para. 30.

⁵¹ CAT/C/CR/32/5, para. 7 (m).

⁵² General comment No. 28, para. 11; see also CCPR/CO.70/ARG, para. 14.

⁵³ WHO, “Access to Controlled Medicines Programme”, briefing note (2012), p. 1.

⁵⁴ Resolutions 53/4 (2010) and 54/6 (2011).

⁵⁵ WHO, “Access”, p. 1.

⁵⁶ See HRW, “*Please Do Not Make Us Suffer Any More...: Access to Pain Treatment as a Human Right* (2009).

⁵⁷ Open Society Foundations, “Palliative care as a human right”, Public Health Fact Sheet, 2012.

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ Ibid.

⁶¹ HRW, *Unbearable Pain: India's Obligation to Ensure Palliative Care* (2009), p. 3.

⁶² Single Convention on Narcotic Drugs, 1961, preamble.

⁶³ Joseph Amon and Diederik Lohman, “Denial of pain treatment and the prohibition of torture, cruel, inhuman or degrading treatment or punishment”, *INTERIGHTS Bulletin*, vol. 16, No. 4 (2011), p. 172.

⁶⁴ See HRW, “*Please Do Not Make Us Suffer*”.

⁶⁵ E/INCB/1999/1, p. 7.

⁶⁶ A/65/255, para. 40.

opioids for medical purposes;⁶⁸ and the absence of pain management policies or guidelines for practitioners.⁶⁹

Applicability of torture and ill-treatment framework

54. Generally, denial of pain treatment involves acts of omission rather than commission,⁷⁰ and results from neglect and poor Government policies, rather than from an intention to inflict suffering. However, not every case where a person suffers from severe pain but has no access to appropriate treatment will constitute cruel, inhuman, or degrading treatment or punishment. This will only be the case when the suffering is severe and meets the minimum threshold under the prohibition against torture and ill-treatment; when the State is, or should be, aware of the suffering, including when no appropriate treatment was offered; and when the Government failed to take all reasonable steps⁷¹ to protect individuals' physical and mental integrity.⁷²

55. Ensuring the availability and accessibility of medications included in the WHO Model List of Essential Medicines is not just a reasonable step but a legal obligation under the Single Convention on Narcotic Drugs, 1961. When the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall foul of the right to health but may also violate an affirmative obligation under the prohibition of torture and ill-treatment (A/HRC/10/44 and Corr.1, para. 72).

56. In a statement issued jointly with the Special Rapporteur on the right to health, the Special Rapporteur on the question of torture reaffirmed that the failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment. Governments must guarantee essential medicines – which include, among others, opioid analgesics – as part of their minimum core obligations under the right to health, and take measures to protect people under their jurisdiction from inhuman and degrading treatment.⁷³

D. Persons with psychosocial disabilities

57. Under article 1 of the Convention on the Rights of Persons with Disabilities, persons with disabilities include those who have long-term intellectual or sensory impairments, which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. These are individuals who have been either neglected or detained in psychiatric and social care institutions, psychiatric wards, prayer

⁶⁷ Palliative care is an approach that seeks to improve the quality of life of patients diagnosed with life-threatening illnesses, through prevention and relief of suffering. WHO Definition of Palliative Care (see www.who.int/cancer/palliative/definition/en/).

⁶⁸ E/INCB/1999/1, p. 7.

⁶⁹ HRW, *“Please Do Not Make Us Suffer”*, p. 2.

⁷⁰ Amon and Lohman, “Denial”, p. 172.

⁷¹ See for example ECHR, *Osman v. United Kingdom*, Application No. 23452/94 (1998), paras. 115-122; Committee on Economic, Social and Cultural Rights, general comment No. 14.

⁷² Amon and Lohman, “Denial”, p. 172.

⁷³ Joint letter to the Chairperson of the fifty-second session of the Commission on Narcotic Drugs, 2008, p. 4.

camps, secular and religious-based therapeutic boarding schools, boot camps, private residential treatment centres or traditional healing centres.⁷⁴

58. In 2008 the mandate made significant strides in the development of norms for the abolition of forced psychiatric interventions on the basis of disability alone as a form of torture and ill-treatment (see A/63/175). The Convention on the Rights of Persons with Disabilities also provides authoritative guidance on the rights of persons with disabilities and prohibits involuntary treatment and involuntary confinement on the grounds of disability, superseding earlier standards such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991 Principles).

59. Severe abuses, such as neglect, mental and physical abuse and sexual violence, continue to be committed against people with psychosocial disabilities and people with intellectual disabilities in health-care settings.⁷⁵

60. There are several areas in which the Special Rapporteur would like to suggest steps beyond what has already been proposed by the mandate in its efforts to promote the Convention on the Rights of Persons with Disabilities as the new normative paradigm and call for measures to combat impunity.

1. A new normative paradigm

61. Numerous calls by the mandate to review the anti-torture framework in relation to persons with disabilities⁷⁶ remain to be addressed. It is therefore necessary to reaffirm that the Convention on the Rights of Persons with Disabilities offers the most comprehensive set of standards on the rights of persons with disabilities, inter alia, in the context of health care, where choices by people with disabilities are often overridden based on their supposed “best interests”, and where serious violations and discrimination against persons with disabilities may be masked as “good intentions” of health professionals (A/63/175, para. 49).

62. It is necessary to highlight additional measures needed to prevent torture and ill-treatment against people with disabilities, by synthesizing standards and coordinating actions in line with the Convention on the Rights of Persons with Disabilities.⁷⁷

2. Absolute ban on restraints and seclusion

63. The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time

⁷⁴ See HRW, “*Like a Death Sentence*”: *Abuses against Persons with Mental Disabilities in Ghana* (2012).

⁷⁵ In November 2012, the Inter-American Commission on Human Rights approved precautionary measures to protect 300 individuals in Guatemala City’s psychiatric facility, where unspeakable forms of abuses were documented.

⁷⁶ See A/58/120; A/63/175, para. 41.

⁷⁷ See for example Organization of American States, Committee for the Elimination of all Forms of Discrimination against Persons with Disabilities, resolution CEDDIS/RES.1 (I-E/11) (2011), annex.

may constitute torture and ill-treatment.⁷⁸ It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.

3. Domestic legislation allowing forced interventions

64. The mandate continues to receive reports of the systematic use of forced interventions worldwide. Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.⁷⁹ Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41). Concern for the autonomy and dignity of persons with disabilities leads the Special Rapporteur to urge revision of domestic legislation allowing for forced interventions.

4. Fully respecting each person’s legal capacity is a first step in the prevention of torture and ill-treatment

65. Millions of people with disabilities are stripped of their legal capacity worldwide, due to stigma and discrimination, through judicial declaration of incompetency or merely by a doctor’s decision that the person “lacks capacity” to make a decision. Deprived of legal capacity, people are assigned a guardian or other substitute decision maker, whose consent will be deemed sufficient to justify forced treatment (E/CN.4/2005/51, para. 79).

66. As earlier stated by the mandate, criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent should be clarified in the law, and no distinction between persons with or without disabilities should be made.⁸⁰ Only in a life-threatening emergency in which there is no disagreement regarding absence of legal capacity may a health-care provider proceed without informed consent to perform a life-saving procedure.⁸¹ From this perspective, several of the 1991 Principles may require reconsideration as running counter to the provisions of the Convention on the Rights of Persons with Disabilities (A/63/175, para. 44).

5. Involuntary commitment in psychiatric institutions

67. In many countries where mental health policies and laws do exist, they focus on confinement of people with mental disabilities in psychiatric institutions but fail to effectively safeguard their human rights.⁸²

⁷⁸ See CAT/C/CAN/CO/6, para. 19 (d); ECHR, *Bures v. Czech Republic*, Application No. 37679/08 (2012), para. 132.

⁷⁹ A/63/175, paras. 44, 47, 61, 63; Human Rights Committee, communication No. 110/1981, *Viana Acosta v. Uruguay*, paras. 2.7, 14, 15.

⁸⁰ See also A/64/272, para. 74.

⁸¹ *Ibid.*, para. 12.

⁸² WHO, “Mental health legislation and human rights – denied citizens: including the excluded”, p. 1.

68. Involuntary commitment to psychiatric institutions has been well documented.⁸³ There are well-documented examples of people living their whole lives in such psychiatric or social care institutions.⁸⁴ The Committee on the Rights of Persons with Disabilities has been very explicit in calling for the prohibition of disability-based detention, i.e. civil commitment and compulsory institutionalization or confinement based on disability.⁸⁵ It establishes that community living, with support, is no longer a favourable policy development but an internationally recognized right.⁸⁶ The Convention radically departs from this approach by forbidding deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory. Article 14, paragraph 1 (b), of the Convention unambiguously states that “the existence of a disability shall in no case justify a deprivation of liberty”. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness (A/HRC/10/48, paras. 48, 49).

69. Deprivation of liberty on grounds of mental illness is unjustified if its basis is discrimination or prejudice against persons with disabilities. Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention.⁸⁷ The Special Rapporteur believes that the severity of the mental illness is not by itself sufficient to justify detention; the State must also show that detention is necessary to protect the safety of the person or of others. Except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of “unsound mind”.⁸⁸ As detention in a psychiatric context may lead to non-consensual psychiatric treatment,⁸⁹ the mandate has stated that deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering could fall under the scope of the Convention against Torture (A/63/175, para. 65). In making such an assessment, factors such as fear and anxiety produced by indefinite detention, the infliction of forced medication or electroshock, the use of restraints and seclusion, the segregation from family and community, etc., should be taken into account.⁹⁰

70. Moreover, the effects of institutionalization of individuals who do not meet appropriate admission criteria, as is the case in most institutions which are off the monitoring radar and lack appropriate admission oversight,⁹¹ raise particular questions under prohibition of torture and ill-treatment. Inappropriate or unnecessary non-consensual

⁸³ See Thomas Hammarberg, “Inhuman treatment of persons with disabilities in institutions”, Human Rights Comment (2010).

⁸⁴ See Dorottya Karsay and Oliver Lewis, “Disability, torture and ill-treatment: taking stock and ending abuses”, *The International Journal of Human Rights*, vol. 16, No. 6 (2012), pp. 816-830.

⁸⁵ See also CRPD/C/HUN/CO/1, paras. 27-28.

⁸⁶ See CRPD/C/CHN/CO/1 and Corr.1, paras. 92-93.

⁸⁷ See Peter Bartlett, “A mental disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention”, *The International Journal of Human Rights*, vol. 16, No. 6 (2012), pp. 831-844.

⁸⁸ See ECHR, *Winterwerp v. The Netherlands*, Application No. 6301/73 (1979) and ECHR, *E v. Norway*, Application No. 11701/85 (1990).

⁸⁹ See Bartlett, “A mental disorder”.

⁹⁰ Stop Torture in Healthcare, “Torture and ill-treatment of people with disabilities in healthcare settings”, Campaign Briefing, 2012.

⁹¹ See CAT/C/JPN/CO/1, para. 26.

institutionalization of individuals may amount to torture or ill-treatment as use of force beyond that which is strictly necessary.⁹²

E. Marginalized groups

1. Persons living with HIV/AIDS

71. Numerous reports have documented mistreatment of or denial of treatment to people living with HIV/AIDS by health providers.⁹³ They are reportedly turned away from hospitals, summarily discharged, denied access to medical services unless they consent to sterilization,⁹⁴ and provided poor quality care that is both dehumanizing and damaging to their already fragile health status.⁹⁵ Forced or compulsory HIV testing is also a common abuse that may constitute degrading treatment if it is “done on a discriminatory basis without respecting consent and necessity requirements” (A/HRC/10/44 and Corr.1, para. 65). Unauthorized disclosure of HIV status to sexual partners, family members, employers and other health workers is a frequent abuse against people living with HIV that may lead to physical violence.

2. Persons who use drugs

72. People who use drugs are a highly stigmatized and criminalized population whose experience of health-care is often one of humiliation, punishment and cruelty. Drug users living with HIV are often denied emergency medical treatment.⁹⁶ In some cases the laws specifically single out the status of a drug user as a stand-alone basis for depriving someone of custody or other parental rights. Use of drug registries – where people who use drugs are identified and listed by police and health-care workers, and their civil rights curtailed – are violations of patient confidentiality⁹⁷ that lead to further ill-treatment by health providers.

73. A particular form of ill-treatment and possibly torture of drug users is the denial of opiate substitution treatment, including as a way of eliciting criminal confessions through inducing painful withdrawal symptoms (A/HRC/10/44 and Corr.1, para. 57). The denial of methadone treatment in custodial settings has been declared to be a violation of the right to be free from torture and ill-treatment in certain circumstances (ibid., para. 71). Similar reasoning should apply to the non-custodial context, particularly in instances where Governments impose a complete ban on substitution treatment and harm reduction measures.⁹⁸ The common practice of withholding anti-retroviral treatment from HIV-positive people who use drugs, on the assumption that they will not be capable of adhering to treatment, amounts to cruel and inhuman treatment, given the physical and psychological suffering as the disease progresses; it also constitutes abusive treatment based on unjustified discrimination solely related to health status.

⁹² ECHR, *Mouisel v. France*, Application No. 67263/01 (2002), para. 48; see also Nell Monroe, “Define acceptable: how can we ensure that treatment for mental disorder in detention is consistent with the UN Convention on the Rights of Persons with Disabilities?”, *The International Journal of Human Rights*, vol. 16, No. 6 (2012).

⁹³ Campaign to Stop Torture in Health Care, “Torture and ill-treatment in health settings: a failure of accountability”, *Interights Bulletin*, vol. 16, No. 4 (2011), p. 162.

⁹⁴ Open Society Foundations, *Against Her Will* (footnote 43 above).

⁹⁵ See HRW, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine’s Fight against HIV/AIDS* (2006).

⁹⁶ Ibid., p. 44.

⁹⁷ A/65/255, para. 20.

⁹⁸ See HRW, *Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation* (2004).

74. By denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependency and of the scientific evidence pointing to the ineffectiveness of punitive measures.

3. Sex workers

75. A report on sex workers documented negative and obstructive attitudes on the part of medical workers, including denial of necessary health-care services.⁹⁹ Public health rationales have in some instances led to mandatory HIV testing and exposure of their HIV status, accompanied by punitive measures.¹⁰⁰ Breaches of privacy and confidentiality are a further indignity experienced by sex workers in health settings.¹⁰¹ Most recently, the Committee against Torture noted “reports of alleged lack of privacy and humiliating circumstances amounting to degrading treatment during medical examinations”.¹⁰² The mandate has observed that acts aimed at humiliating the victim, regardless of whether severe pain has been inflicted, may constitute degrading treatment or punishment because of the incumbent mental suffering (E/CN.4/2006/6, para. 35).

4. Lesbian, gay, bisexual, transgender and intersex persons

76. The Pan American Health Organization (PAHO) has concluded that homophobic ill-treatment on the part of health professionals is unacceptable and should be proscribed and denounced.¹⁰³ There is an abundance of accounts and testimonies of persons being denied medical treatment, subjected to verbal abuse and public humiliation, psychiatric evaluation, a variety of forced procedures such as sterilization, State-sponsored forcible anal examinations for the prosecution of suspected homosexual activities, and invasive virginity examinations conducted by health-care providers,¹⁰⁴ hormone therapy and genital-normalizing surgeries under the guise of so called “reparative therapies”.¹⁰⁵ These procedures are rarely medically necessary,¹⁰⁶ can cause scarring, loss of sexual sensation, pain, incontinence and lifelong depression and have also been criticized as being unscientific, potentially harmful and contributing to stigma (A/HRC/14/20, para. 23). The Committee on the Elimination of Discrimination against Women expressed concern about lesbian, bisexual, transgender and intersex women as “victims of abuses and mistreatment by health service providers” (A/HRC/19/41, para. 56).

77. Children who are born with atypical sex characteristics are often subject to irreversible sex assignment, involuntary sterilization, involuntary genital normalizing surgery, performed without their informed consent, or that of their parents, “in an attempt to

⁹⁹ Campaign to Stop Torture in Health Care, “Torture”, p. 163; see also A/64/272, para. 85.

¹⁰⁰ WHO and the Global Coalition on Women and AIDS, “Violence against sex workers and HIV prevention” (WHO, 2005), p. 2.

¹⁰¹ Campaign to Stop Torture in Health Care, “Torture”, p. 163.

¹⁰² CAT/C/AUT/CO/4-5, para. 22.

¹⁰³ PAHO, “‘Cures’ for an illness that does not exist” (2012), p. 3.

¹⁰⁴ See HRW, *In a Time of Torture: The Assault on Justice in Egypt’s Crackdown on Homosexual Conduct* (2003).

¹⁰⁵ PAHO/WHO, “‘Therapies’ to change sexual orientation lack medical justification and threaten health”, news statement, 17 May 2012; and submission by Advocates for Informed Choice to the Special Rapporteur on the question of torture, 2012.

¹⁰⁶ PAHO/WHO, “‘Therapies’”.

fix their sex”,¹⁰⁷ leaving them with permanent, irreversible infertility and causing severe mental suffering.

78. In many countries transgender persons are required to undergo often unwanted sterilization surgeries as a prerequisite to enjoy legal recognition of their preferred gender. In Europe, 29 States require sterilization procedures to recognize the legal gender of transgender persons. In 11 States where there is no legislation regulating legal recognition of gender,¹⁰⁸ enforced sterilization is still practised. As at 2008, in the United States of America, 20 states required a transgender person to undergo “gender-confirming surgery” or “gender reassignment surgery” before being able to change their legal sex.¹⁰⁹ In Canada, only the province of Ontario does not enforce “transsexual surgery” in order to rectify the recorded sex on birth certificates.¹¹⁰ Some domestic courts have found that not only does enforced surgery result in permanent sterility and irreversible changes to the body, and interfere in family and reproductive life, it also amounts to a severe and irreversible intrusion into a person’s physical integrity. In 2012, the Swedish Administrative Court of Appeals ruled that a forced sterilization requirement to intrude into someone’s physical integrity could not be seen as voluntary.¹¹¹ In 2011, the Constitutional Court in Germany ruled that the requirement of gender reassignment surgery violated the right to physical integrity and self-determination.¹¹² In 2009, the Austrian Administrative High Court also held that mandatory gender reassignment, as a condition for legal recognition of gender identity, was unlawful.¹¹³ In 2009, the former Commissioner for Human Rights of the Council of Europe observed that “[the involuntary sterilization] requirements clearly run counter to the respect for the physical integrity of the person”.¹¹⁴

79. The mandate has noted that “members of sexual minorities are disproportionately subjected to torture and other forms of ill-treatment because they fail to conform to socially constructed gender expectations. Indeed, discrimination on grounds of sexual orientation or gender identity may often contribute to the process of the dehumanization of the victim, which is often a necessary condition for torture and ill-treatment to take place.”¹¹⁵ “Medically worthless” practices of subjecting men suspected of homosexual conduct to non-consensual anal examinations to “prove” their homosexuality¹¹⁶ have been condemned by the Committee against Torture, the Special Rapporteur on the question of torture and the Working Group on Arbitrary Detention, which have held that the practice contravenes the prohibition of torture and ill-treatment (A/HRC/19/41, para. 37).

5. Persons with disabilities

80. Persons with disabilities are particularly affected by forced medical interventions, and continue to be exposed to non-consensual medical practices (A/63/175, para. 40). In the case of children in health-care settings, an actual or perceived disability may diminish the

¹⁰⁷ A/HRC/19/41, para. 57.

¹⁰⁸ Commissioner for Human Rights of the Council of Europe, *Discrimination on Grounds of Sexual Orientation and Gender Identity in Europe* (2011), pp. 86-87.

¹⁰⁹ D. Spade, “Documenting gender”, *Hastings Law Journal*, vol. 59, No. 1 (2008), pp. 830-831.

¹¹⁰ *XY v. Ontario*, 2012 HRTO 726 (CanLII), judgement of 11 April 2012.

¹¹¹ Mål nr 1968-12, Kammarrätten i Stockholm, Avdelning 03, http://du2.pentagonvillan.se/images/stories/Kammarrtens_dom_-_121219.pdf, p. 4.

¹¹² Federal Constitutional Court, *1 BvR 3295/07*. Available from www.bundesverfassungsgericht.de/entscheidungen/rs20110111_1bvr329507.html.

¹¹³ Administrative High Court, No. 2008/17/0054, judgement of 27 February 2009.

¹¹⁴ “Human rights and gender identity”, issue paper (2009), p. 19.

¹¹⁵ A/56/156, para. 19. See also E/CN.4/2001/66/Add.2, para. 199.

¹¹⁶ Working Group on Arbitrary Detention, opinion No. 25/2009 (2009), para. 29.

weight given to the child's views¹¹⁷ in determining their best interests, or may be taken as the basis of substitution of determination and decision-making by parents, guardians, carers or public authorities.¹¹⁸ Women living with disabilities, with psychiatric labels in particular, are at risk of multiple forms of discrimination and abuse in health-care settings. Forced sterilization of girls and women with disabilities has been widely documented.¹¹⁹ National law in Spain, among other countries,¹²⁰ allows for the sterilization of minors who are found to have severe intellectual disabilities. The Egyptian Parliament failed to include a provision banning the use of sterilization as a "treatment" for mental illness in its patient protection law. In the United States, 15 states have laws that fail to protect women with disabilities from involuntary sterilization.¹²¹

V. Conclusions and recommendations

A. Significance of categorizing abuses in health-care settings as torture and ill-treatment

81. The preceding examples of torture and ill-treatment in health-care settings likely represent a small fraction of this global problem. Such interventions always amount at least to inhuman and degrading treatment, often they arguably meet the criteria for torture, and they are always prohibited by international law.

82. The prohibition of torture is one of the few absolute and non-derogable human rights,¹²² a matter of *jus cogens*,¹²³ a peremptory norm of customary international law. Examining abuses in health-care settings from a torture protection framework provides the opportunity to solidify an understanding of these violations and to highlight the positive obligations that States have to prevent, prosecute and redress such violations.

83. The right to an adequate standard of health care ("right to health") determines the States' obligations towards persons suffering from illness. In turn, the absolute and non-derogable nature of the right to protection from torture and ill-treatment establishes objective restrictions on certain therapies. In the context of health-related abuses, the focus on the prohibition of torture strengthens the call for accountability and strikes a proper balance between individual freedom and dignity and public health concerns. In that fashion, attention to the torture framework ensures that system inadequacies, lack of resources or services will not justify ill-treatment. Although resource constraints may justify only partial fulfilment of some aspects of the right to health, a State cannot justify its non-compliance with core obligations, such as the absolute prohibition of torture, under any circumstances.¹²⁴

84. By reframing violence and abuses in health-care settings as prohibited ill-treatment, victims and advocates are afforded stronger legal protection and redress

¹¹⁷ Committee on the Rights of the Child, general comment No. 12 (2009), para. 21.

¹¹⁸ See A/HRC/20/5, para. 53 (d); A/63/175, para. 59.

¹¹⁹ See Independent Expert for the Secretary-General's Study on Violence against Children, *World Report on Violence against Children* (2009).

¹²⁰ Open Society Foundations, *Against Her Will* (footnote 43 above), p. 6, A/64/272, para. 71.

¹²¹ Open Society Foundations, *Against Her Will*, p. 6.

¹²² Convention against Torture, art. 2, para. 2, International Covenant on Civil and Political Rights, art. 7.

¹²³ See International Criminal Tribunal for the Former Yugoslavia, *Prosecutor v. Furundzija*, case No. IT-95-17/1-T, judgement (1998).

¹²⁴ See Committee on Economic, Social and Cultural Rights, general comment No. 14.

for violations of human rights. In this respect, the recent general comment No. 3 (2012) of the Committee against Torture on the right to a remedy and reparation offers valuable guidance regarding proactive measures required to prevent forced interventions. Notably, the Committee considers that the duty to provide remedy and reparation extends to all acts of ill-treatment,¹²⁵ so that it is immaterial for this purpose whether abuses in health-care settings meet the criteria for torture per se. This framework opens new possibilities for holistic social processes that foster appreciation of the lived experiences of persons, including measures of satisfaction and guarantees of non-repetition, and the repeal of inconsistent legal provisions.

B. Recommendations

85. The Special Rapporteur calls upon all States to:

(a) Enforce the prohibition of torture in all health-care institutions, both public and private, by, inter alia, declaring that abuses committed in the context of health-care can amount to torture or cruel, inhuman or degrading treatment or punishment; regulating health-care practices with a view to preventing mistreatment under any pretext; and integrating the provisions of prevention of torture and ill-treatment into health-care policies;

(b) Promote accountability for torture and ill-treatment in health-care settings by identifying laws, policies and practices that lead to abuse; and enable national preventive mechanisms to systematically monitor, receive complaints and initiate prosecutions;

(c) Conduct prompt, impartial and thorough investigations into all allegations of torture and ill-treatment in health-care settings; where the evidence warrants it, prosecute and take action against perpetrators; and provide victims with effective remedy and redress, including measures of reparation, satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation;

(d) Provide appropriate human rights education and information to health-care personnel on the prohibition of torture and ill-treatment and the existence, extent, severity and consequences of various situations amounting to torture and cruel, inhuman or degrading treatment or punishment; and promote a culture of respect for human integrity and dignity, respect for diversity and the elimination of attitudes of pathologization and homophobia. Train doctors, judges, prosecutors and police on the standards regarding free and informed consent;

(e) Safeguard free and informed consent on an equal basis for all individuals without any exception, through legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be revised. Adopt policies and protocols that uphold autonomy, self-determination and human dignity. Ensure that information on health is fully available, acceptable, accessible and of good quality; and that it is imparted and comprehended by means of supportive and protective measures such as a wide range of community-based services and supports (A/64/272, para. 93). Instances of treatment without informed consent should be investigated; redress to victims of such treatment should be provided;

¹²⁵ General comment No. 3, para. 1.

(f) Ensure special protection of minority and marginalized groups and individuals as a critical component of the obligation to prevent torture and ill-treatment¹²⁶ by, inter alia, investing in and offering marginalized individuals a wide range of voluntary supports that enable them to exercise their legal capacity and that fully respect their individual autonomy, will and preferences.

1. Denial of pain relief

86. The Special Rapporteur calls upon all States to:

(a) Adopt a human rights-based approach to drug control as a matter of priority to prevent the continuing violations of rights stemming from the current approaches to curtailing supply and demand (A/65/255, para. 48). Ensure that national drug control laws recognize the indispensable nature of narcotic and psychotropic drugs for the relief of pain and suffering; review national legislation and administrative procedures to guarantee adequate availability of those medicines for legitimate medical uses;

(b) Ensure full access to palliative care and overcome current regulatory, educational and attitudinal obstacles that restrict availability to essential palliative care medications, especially oral morphine. States should devise and implement policies that promote widespread understanding about the therapeutic usefulness of controlled substances and their rational use;

(c) Develop and integrate palliative care into the public health system by including it in all national health plans and policies, curricula and training programmes and developing the necessary standards, guidelines and clinical protocols.

2. Compulsory detention for medical reasons

87. The Special Rapporteur calls upon all States to:

(a) Close compulsory drug detention and “rehabilitation” centres without delay and implement voluntary, evidence-based and rights-based health and social services in the community. Undertake investigations to ensure that abuses, including torture or cruel, inhuman and degrading treatment, are not taking place in privately-run centres for the treatment of drug dependence;

(b) Cease support for the operation of existing drug detention centres or the creation of new centres. Any decision to provide funding should be made only following careful risk assessment. If provided, any such funds should be clearly time-limited and provided only on the conditions that the authorities (a) commit to a rapid process for closing drug detention centres and reallocating said resources to scaling up voluntary, community-based, evidence-based services for treatment of drug dependence; and (b) replace punitive approaches and compulsory elements to drug treatment with other, evidence-based efforts to prevent HIV and other drug-related harms. Such centres, while still operating as the authorities move to close them, are subject to fully independent monitoring;

(c) Establish an effective mechanism for monitoring dependence treatment practices and compliance with international norms;

¹²⁶ See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 43 (a)-(f).

(d) Ensure that all harm-reduction measures and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations (A/65/255, para. 76).

3. Lesbian, gay, bisexual, transgender and intersex persons

88. The Special Rapporteur calls upon all States to repeal any law allowing intrusive and irreversible treatments, including forced genital-normalizing surgery, involuntary sterilization, unethical experimentation, medical display, “reparative therapies” or “conversion therapies”, when enforced or administered without the free and informed consent of the person concerned. He also calls upon them to outlaw forced or coerced sterilization in all circumstances and provide special protection to individuals belonging to marginalized groups.

4. Persons with psychosocial disabilities

89. The Special Rapporteur calls upon all States to:

(a) Review the anti-torture framework in relation to persons with disabilities in line with the Convention on the Rights of Persons with Disabilities as authoritative guidance regarding their rights in the context of health-care;

(b) Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation;¹²⁷

(c) Replace forced treatment and commitment by services in the community. Such services must meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned, with an emphasis on alternatives to the medical model of mental health, including peer support, awareness-raising and training of mental health-care and law enforcement personnel and others;

(d) Revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished.

5. Reproductive rights

90. The Special Rapporteur calls upon all States to ensure that women have access to emergency medical care, including post-abortion care, without fear of criminal penalties or reprisals. States whose domestic law authorizes abortions under various circumstances should ensure that services are effectively available without adverse consequences to the woman or the health professional.

¹²⁷ Convention on the Rights of Persons with Disabilities, art. 4, para. 2.