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A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence

Note by the Secretary-General

The Secretary-General has the honour to transmit to the members of the General Assembly the report of the Special Rapporteur on violence against women, its causes and consequences, Dubravka Šimonović, submitted in accordance with Assembly resolution [71/170](#).

* [A/74/50](#).



**Report of the Special Rapporteur on violence against women,
its causes and consequences on a human rights-based
approach to mistreatment and violence against women in
reproductive health services with a focus on childbirth and
obstetric violence**

Summary

- In the present report, the Special Rapporteur on violence against women, its causes and consequences analyses the issue of mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, as well as the root causes and structural issues that need to be addressed to combat such forms of mistreatment and violence.

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I. Introduction

1. The present report by Dubravka Šimonović, the Special Rapporteur of the Human Rights Council on violence against women, its causes and consequences, is submitted pursuant to General Assembly resolution 71/170. In section II of the report, the Special Rapporteur summarizes the activities carried out under the mandate during the reporting period, up until July 2019. In section III, the Rapporteur analyses mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, and identifies the root causes of mistreatment as well as structural challenges. In section IV, the Rapporteur sets out her conclusion and recommendations on preventing and combating mistreatment and violence against women in reproductive health services and during childbirth.

II. Activities

2. During the reporting period, the Special Rapporteur worked to consolidate the platform for cooperation between international and regional independent mechanisms on violence against women and women's rights, launched as an initiative under the mandate, as well as cooperation with the Committee on the Elimination of Discrimination against Women. At the forty-first session of the Human Rights Council, in June 2019, the Special Rapporteur presented: (a) her thematic report on the mandate, including a chapter on the 25-years of its existence and an analysis of its evolution, the current challenges and the way forward – contribution to the 25-year review of the Beijing Declaration and Platform for Action (A/HRC/41/42) and (b) the reports on her country visits to Canada (A/HRC/41/42/Add.1) and Nepal (A/HRC/41/42/Add.2).

3. On 1 July 2019, the Special Rapporteur participated in the seventy-third session of the Committee on the Elimination of Discrimination against Women at which she discussed cooperation between her mandate and the Committee related to the promotion of its general recommendation 35 on gender-based violence against women and the establishment of the platform for cooperation between international and regional independent women's human rights mechanisms.¹

III. A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence

A. Introduction

4. In recent years, the mistreatment and violence against women experienced during facility-based childbirth and in other reproductive health services has gained global attention, inter alia, through the numerous testimonies posted by women and women's organizations on social media; this form of violence has been shown to be widespread and systematic in nature. In recognizing that these issues have not been fully addressed from a human rights perspective, the Special Rapporteur decided to prepare her thematic report on mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence.

5. As the leading health organization of the United Nations system, the World Health Organization (WHO) reacted to the growing concerns of women during

¹ <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24780&LangID=E>.

childbirth by issuing a statement in 2015 condemning “outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.”² In its statement, WHO also recognized that “such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity and freedom from discrimination.”

6. In preparing her report, the Special Rapporteur and WHO jointly convened an expert group meeting in Geneva on 25 and 26 April 2019 on mistreatment during childbirth within the context of human rights and violence against women. The Special Rapporteur also issued a call for inputs and requested information on forms of mistreatment, informed consent, accountability mechanisms and examples of national health responses to violence against women. Over 128 submissions were received from States, non-governmental organizations, independent institutions and academics.³ Several non-governmental organizations have also published reports documenting the abuses women and girls experience during childbirth in health-care facilities around the world.⁴

7. The Parliamentary Assembly of the Council of Europe has also decided to publish a report on obstetrical and gynaecological violence and the Special Rapporteur has had exchanges with the rapporteur of the Parliamentary Assembly who is working on that report.⁵

B. Scope of the report

8. In the present report, the Special Rapporteur aims to apply a human rights-based approach to the different forms of mistreatment and violence that women experience in reproductive health services with a focus on childbirth and obstetric violence. Mistreatment and violence against women not only violates the rights of women to live a life free from violence but can also threaten their rights to life, health, bodily integrity, privacy, autonomy and freedom from discrimination.

9. Mistreatment and violence against women in reproductive health services and during childbirth is addressed in the report as part of a continuum of the violations that occur in the wider context of structural inequality, discrimination and patriarchy, and are also the result of a lack of proper education and training as well as lack of respect for women’s equal status and human rights. Such violence is experienced by

² World Health Organization (WHO) statement, “The prevention and elimination of disrespect and abuse during facility-based childbirth”, WHO/RHR/14.23 (2015).

³ All submissions are available on the website of the Special Rapporteur on violence against women, its causes and consequences: <https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>.

⁴ See for example, Center for Reproductive Rights, *Failure to Deliver: Violations of Women’s Human Rights in Kenyan Health Facilities* (2007); Amnesty International, *Deadly Delivery: The Maternal Health Care Crisis in America*, London, 2010; Human Rights Watch, “*Stop Making Excuses*”: *Accountability for Maternal Health Care in South Africa* (2011); Janka Debrecéniová, ed., *Women – Mothers – Bodies: Women’s Human Rights in Obstetric Care in Healthcare Facilities in Slovakia*, Citizen, Democracy and Accountability (2015); and Center for Reproductive Rights, *Vakeras Zorales – Speaking Out: Roma Women’s Experiences in Reproductive Health Care in Slovakia* (2017).

⁵ Parliamentary Assembly of the Council of Europe, document No. 14495 (26 January 2018); meeting on obstetrical and gynaecological violence, held in Zagreb 3 July 2019.

women and girls when seeking other forms of sexual and reproductive healthcare, including gynaecological examinations, abortion, fertility treatments and contraception and in other sexual and reproductive health contexts.

10. The report provides recommendations on how to address the structural problems and root causes of violence against women in reproductive health services with a focus on childbirth and obstetric violence. The report also seeks to lay the foundation for States in upholding their human rights obligations and developing appropriate laws, policies, national women reproductive health strategies and complaint mechanisms to ensure a human rights-based approach to healthcare and accountability for human rights violations. Under international law, acts or omissions by non-State actors attributable to the State include the “acts or omissions of private actors empowered by the law [of that State] to exercise elements of governmental authority, including private bodies providing public services, such as healthcare or education, or operating places of detention, are considered as acts attributable to the State itself”.⁶ States parties also have an obligation under the Convention on the Elimination of All Forms of Discrimination against Women to pursue, by all appropriate means and without delay, a policy of eliminating discrimination and gender-based violence against women, including in the field of health. This is an obligation of an immediate nature and delays cannot be justified on any grounds, including economic, cultural or religious grounds.

11. Noting that the United Nations Population Fund (UNFPA) has recognized that “at the global level, there is a lack of global consensus on how violence against women during facility-based childbirth is defined and measured”⁷ and that a similar concern was expressed by one non-governmental organization, which noted that “... violence against women in childbirth is so normalized that it is not (yet) considered violence against women”,⁸ the Special Rapporteur points out that the following definition of violence against women, as enshrined in article 1 of the Declaration on the Elimination of Violence against Women, is applicable to all forms of mistreatment and violence against women in reproductive health services and childbirth: “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”.⁹ General recommendation 19 of the Committee on the Elimination of Discrimination against Women defines gender-based violence against women as “violence which is directed against a woman because she is a woman or that affects women disproportionately”¹⁰ while the jurisprudence from the Committee and other judicial and monitoring bodies in individual cases further elaborates on specific forms of violence against women related to reproductive health and human rights of women.

12. With respect to the terminology, the Special Rapporteur will use the term “obstetric violence” when referring to violence experienced by women during facility-based childbirth. Obstetric violence is a term widely used in South America, but it is not yet in use in international human rights law and, in order to address it

⁶ Committee on the Elimination of Discrimination against Women, general recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, CEDAW/C/GC/35, para. 24 (a).

⁷ Submission of the United Nations Population Fund (UNFPA) to the Special Rapporteur; available at: <https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>.

⁸ Submission of Mother Hood e.V to the Special Rapporteur, available at: <https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>.

⁹ Declaration on the Elimination of Violence against Women (resolution 48/104 of 20 December 1993).

¹⁰ See Committee on the Elimination of Discrimination against Women, general recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19 (CEDAW/C/GC/35, para. 1).

under the existing international framework on the human rights of women, the Special Rapporteur will also use “violence against women during childbirth”. At the regional level, the Committee of Experts of the Follow-up Mechanism of the Belém do Pará Convention, which was the first mechanism to recognize obstetric violence as a human rights violation, recommended that States adopt legal provisions that criminalize obstetric violence. As a result, several countries in the Latin America and Caribbean region have adopted laws that criminalize obstetric violence.¹¹

13. While there is an array of existing terms, including “mistreatment”, “disrespect”, “abuse”, “physical violence” and “violence against women”, for the sake of clarity the Special Rapporteur has decided to use the terms “mistreatment” and “violence against women” in her report. The Special Rapporteur acknowledges that many forms of mistreatment related to childbirth and other reproductive health services are not deliberate or intentional acts of violence against women, although certain acts or omissions (see para. 10 above) could be considered as such. It should be noted, however, that in certain circumstances some forms of mistreatment could amount to violence against women in individual cases, depending on circumstances, while others could be determined to be human rights violations based on human rights standards and human rights jurisprudence.

14. The report also addresses the issue of informed consent as a human right and a safeguard against such violence. Women are frequently denied their right to make informed decisions about the healthcare they receive during childbirth and other reproductive health services; this lack of informed consent constitutes a human rights violation that could be attributed to States and national health systems.

C. Manifestations of mistreatment and gender-based violence in reproductive health-care services and during facility-based childbirth

15. Through the submissions received and other resources, the Special Rapporteur has been able to identify manifestations of gender-based violence in reproductive health-care services and during facility-based childbirth. This list is not exhaustive.

16. The painful stories told by women through the submissions received by the Special Rapporteur revealed that mistreatment and violence against women in reproductive health-care services and childbirth in health facilities happen all around the world and affect women across all socioeconomic levels. New digital social platforms have played an essential role in breaking the silence and have allowed women to share their experiences and tell their stories. Similar to the #MeToo movement, the information posted on such platforms has confirmed that women who are victims of obstetric violence are often silenced or afraid of speaking out because of a fear of taboos, stigma or a feeling that the violence they have experienced could constitute an isolated incident; testimonies from women have shown that mistreatment and violence during childbirth is widespread and engrained in the health system.

17. New social movements demanding rights for women in reproductive health services and during childbirth, which have arisen since 2015 in several countries, have shed light on the patterns of mistreatment and violence that women suffer, include campaigns in: Italy; (#bastacere: le madri hanno voce); Croatia (#PrekinimoSutnju); France (#PayeTonUtérus); the Netherlands (#Genoeggezwegen); Hungary (#Másállapot); and Finland (the Roses revolution and #Minä Myös Synnyttäjänä).

¹¹ See, for example, article 15 of the law on integrated protection of women, No. 26.485/2009, Bolivarian Republic of Venezuela.

Within only two weeks of its introduction, in May 2019, the latter campaign had received 150 accounts of violence, human rights violations and inappropriate conduct in maternity care, during prenatal care and birth, as well as during postpartum care.

18. In Ireland, following the death of a mother and her baby in a maternity unit in January 2019, a woman phoned a national radio station to describe her own experience of mistreatment, neglect and unsafe conditions during her recent labour and birth. Following this initial phone call, more than 1,000 women contacted the programme, and in a subsequent broadcast, aired from 2 to 10 April, women's experiences of unsafe care, disrespect, abuse and mistreatment in the Irish maternity system were presented in depth.¹²

19. A Swedish non-governmental organization pointed out the failure of the Government to provide options for out-of-hospital birth (at birthing centres as well as assisted home birth), despite the proven superior safety of such options and their potential to mitigate the problem of obstetric violence, as well as the lack of evidence-based care and the physical consequences of the over-medicalization of childbirth, which often leads to birth injuries. In the view of the organization, such failures are reflective of misogyny and the fact that women's immediate and long-term mental and physical health is not being prioritized.¹³

20. The technique known as symphysiotomy, which has already been determined to be a human rights violation and a form of violence against women that could amount to torture, is the surgical separation and widening of the pelvis to facilitate childbirth. This birthing practice, used mainly in Ireland until the early 1990s, without the knowledge or the free and informed consent of the women concerned, caused lifelong pain and disability to numerous women. The Committee against Torture addressed the complaints of numerous women related to this technique and found that it constitutes torture. In 2017, the Committee recommended that the State carry out an "impartial, thorough investigation into the cases of women who have been subjected to [it] (...) and ensure that survivors of symphysiotomy obtain redress, including compensation and rehabilitation, determined on an individual basis". It also declared that "doctors declined to perform alternative procedures that would have caused substantially less pain and suffering for religious rather than medical reasons".¹⁴ The Human Rights Committee determined that 1,500 women and girls had been subjected to symphysiotomy between 1944 and 1987 without their free and informed consent.¹⁵ The Committee on the Elimination of Discrimination against Women called on the State to carry out prompt, independent and thorough investigations into cases into all allegations of abuse, including symphysiotomy, and recommended that all victims/survivors of such abuse obtain an effective remedy and rehabilitative services.¹⁶

21. Forced sterilization and forced abortion are crimes and forms of gender-based violence against women. The Council of Europe Convention on preventing and combating violence against women and domestic violence, known as the Istanbul Convention, explicitly prohibits both, while the Convention on the Elimination of All Forms of Discrimination against Women and other United Nations human rights treaties prohibit them implicitly through the protection of women's human and

¹² Submission of the Irish Maternity Support Network to the Special Rapporteur, available at: <https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>.

¹³ See <https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/F%c3%b6delsehuset.pdf>.

¹⁴ Committee against Torture, concluding observations, Ireland (CAT/C/IRL/CO/2, paras. 29–30).

¹⁵ Human Rights Committee, 2014, concluding observations on the fourth periodic report of Ireland, CCPR/C/IRL/CO/4, para. 11.

¹⁶ See Committee on the Elimination of Discrimination against Women, 2017 Concluding Observations, Ireland, CEDAW/C/IRL/CO/6-7, para. 15 (a).

reproductive rights. Forced sterilization and abortion are medical treatments practiced without informed consent across the globe. They are carried out by health professionals for multiple reasons, for example as being somehow in the so-called best interest of the woman,¹⁷ or based on the belief that certain groups of women from minority groups, such as Roma women, indigenous women, women with disabilities and women living with HIV, are not “worthy” of procreation, are incapable of making responsible decisions regarding contraception, are not fit to be “good mothers” or that their offspring are not desirable. Some providers also withhold information or mislead women into consenting to sterilization, acting, in the words of the European Court of Human Rights, with “gross disregard for her right to autonomy and choice as a patient”.¹⁸ These medical interventions have been addressed by the Committee on the Elimination of Discrimination against Women and regional courts and they have been qualified as forms of gender-based violence against women that may result in physical and psychological harm and that may amount to torture or cruel, inhuman and degrading treatment.¹⁹

22. In certain States, incarcerated women are “physically restrained during labour with bed restraints and mouth gags.”²⁰ Moreover, pregnant women in prisons and jails or held in detention because of their immigration status, are reported to be shackled and restrained “during labour, delivery and the post-delivery recovery period, for hours or even days, despite the fact that armed guards are with them at all times.”²¹ Such measures have been recognized as human rights violations. In its concluding observations, the Committee against Torture has condemned the shackling of women during childbirth.²² It was reported that women are tied to the bed during childbirth, abortion or miscarriage; a practice that is not supported by WHO and which may amount to violence against women and other human rights violations.

23. The post-childbirth detention of women and their newborns in health-care facilities because of their inability to pay hospital fees is another example of a human rights violation. This practice has been reported in a number of countries in Asia, sub-Saharan Africa, Latin America and the Middle East.²³ In Kenya, detained women and their infants have been made to sleep on the floor, denied adequate food and watched over by guards. There are reports of women and their children spending weeks, and even years, in such conditions.²⁴ In its concluding observations, the Committee

¹⁷ Report of the Special Rapporteur on torture and other cruel, inhuman and degrading treatment, [A/HRC/22/53](#), para. 32.

¹⁸ *V.C. v. Slovakia*, No. 18968/07, European Court of Human Rights, (2012), para. 119.

¹⁹ Committee on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, [CEDAW/C/GC/35](#), para. 18.

²⁰ M.A. Bohren, J.P. Vogel, E.C. Hunter, et al., “The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review”, *PLoS Medicine*, Vol. 12 (6) (2015) [hereinafter, “Bohren et al. (2015)”].

²¹ Center for Reproductive Rights (https://www.reproductiverights.org/sites/err.civicaactions.net/files/documents/CRR_Submission_on_Human_Rights_Abuses_of_US_Incarcerated_Pregnant_Women.pdf).

²² Committee against Torture, concluding observations, United States of America, [CAT/C/USA/CO/2](#), para. 33.

²³ Yates et. al, *Hospital Detentions for Non-payment of Fees: A Denial of Rights and Dignity*, Chatham House (2017), available at: <https://www.chathamhouse.org/sites/default/files/publications/research/2017-12-06-hospital-detentions-non-payment-yates-brookes-whitaker.pdf>; see also “AP Investigation: Hospital patients held hostage for cash”, AP News, (25 October 2018) (<https://apnews.com/4ee597e099be4dfaa899f85e652605b5>); and Bohren et al. (2015), p. 19.

²⁴ Center for Reproductive Rights, *Failure to Deliver: Violations of Women’s Human Rights in Kenyan Health Facilities* (2007), pp. 56–58.

against Torture has condemned the “practice of post-delivery detention of women unable to pay their medical bills” in Kenya.²⁵

24. Caesarean section or caesarian delivery is the use of surgery to deliver babies when medically necessary and when a vaginal delivery would put the mother or the baby at risk. When medically justified, it is a lifesaving procedure. Recently, however, there has been a growing overuse of the procedure around the globe, and in Latin America and Europe it is replacing vaginal birth or is being selected as a preferred way of birth. In many legal contexts, the interest of the fetus override the rights of the pregnant woman, which leads to situations where women purposely are not consulted with regard to the decision as to whether to deliver the baby by caesarean section. There is also evidence that suggests that women are becoming victims of failing health systems where services are planned and managed with a focus on time- and cost-efficiency. Furthermore, caesarian sections can be scheduled and can take place on selected week days, as opposed to weekends, and doctors usually get higher fees from private insurance companies for the procedure.²⁶ When practiced without a woman’s consent, caesarian sections may amount to gender-based violence against women and even torture. The Working Group on the issue of discrimination against women in law and practice has specifically pointed to the overuse of the caesarean section procedure in many countries as evidence of the over medicalization of birth and has suggested that “women are not given a free choice between different ways of giving birth”, especially if the first one is caesarean section.²⁷

25. An episiotomy is a deep cut in a woman’s perineum into the pelvic floor muscle, designed to surgically help women who are delivering a child vaginally. While the procedure may be of benefit to the infant and the mother, if medically necessary, if unnecessary and/or done without informed consent, it may have adverse physical and psychological effects on the mother, can lead to death and may amount to gender-based violence and torture and inhuman and degrading treatment. Numerous inputs were received from women concerned about its use without informed consent. Another problem is its overuse or routine use, contrary to WHO recommendations.²⁸ The use of episiotomy varies, from 30 per cent of women delivering vaginally in Mexico, 50 per cent in Italy²⁹ and up to 89 per cent in Spain.³⁰ In particular, it was reported that 61 per cent of women in Italy who were subjected to an episiotomy were not given appropriate information and that their informed consent was not sought. Episiotomies, including stitching after birth when practiced without informed consent and without anaesthesia, may have significant repercussions on a woman’s reproductive and sexual life and mental health and the long-lasting scars from this practice accompany a woman for the rest of her life. When not justified by medical necessity, it should be considered to be a violation of women’s rights and a form of gender-based violence against women.

26. The use of inexperienced medical staff to carry out gynaecological examinations, may cause harm to pregnant women, and the overuse of synthetic oxytocin as an agent used to induce contractions and labour also presents a danger to

²⁵ Committee against Torture, concluding observations, Kenya, [CAT/C/KEN/CO/2](#), para. 27.

²⁶ Submission of UNFPA to the Special Rapporteur on violence against women, available at: <https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>.

²⁷ Report of the Working Group on the issue of discrimination against women in law and in practice, [A/HRC/32/44](#), para. 74.

²⁸ <https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/care-during-childbirth/care-during-labour-2nd-stage/who-recommendation-episiotomy-policy-0>.

²⁹ Submission of the Italian Observatory for Domestic Violence to the Special Rapporteur, available at: <https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>.

³⁰ Wagner, Marsden (2000), *El nacimiento en el nuevo milenio*, ponencia presentada en el I Congreso Internacional de Parto en Casa, Jerez de la Frontera, Cádiz disponible en <https://www.elpartoestuestro.es/sites/default/files/public/documentos/parto/partomedicalizado/0>.

their health. Managed improperly, the use of oxytocin can cause stillbirth and uterine rupture, and can cause the mother excruciating pain if not accompanied with appropriate pain relief.³¹

27. The application of manual fundal pressure to facilitate childbirth during the second stage of labour, known as the Kristeller manoeuvre, is no longer recommended by WHO³² but it is still widely practiced, sometimes with the elbow, forearm or with the whole body, to provoke expulsion of the baby. Its application varies from country to country, reaching the highest rates of application in Honduras where it is used in between the 50 per cent and 70 per cent of vaginal births.

28. In addition, women have reported that some providers have acted without respect for privacy and confidentiality when performing vaginal examinations during labour, including in front of third parties;³³ permitting medical student to observe women during childbirth;³⁴ and sharing women's health information, including HIV status, with third parties in the context of childbirth.

29. Additionally, it was reported that surgical miscarriage procedures, uterine scraping, stitching after birth and egg retrieval during medically assisted procreation are oftentimes carried out without anaesthesia. Moreover, several women described being victims of tight stitching after episiotomies; this procedure, known as the "husband stitch", is supposedly carried out to please the husband. This practice is the consequence of harmful patriarchal stereotypes and unequal relations between men and women. The Special Rapporteur on torture of the Human Rights Council has noted that "Abuses range from extended delays in the provision of medical care, such as stitching after delivery to the absence of anaesthesia".³⁵

30. Women also reported a lack of autonomy and decision-making, including the chance to choose their preferred position for delivery during childbirth in public hospitals, while there is more flexibility over the choice of birthing position in private maternal facilities.

31. Practices of profound humiliation, verbal abuse and sexist remarks during childbirth were reported by numerous women from different parts of the world, and they take place behind the closed doors of health facilities. Only recently have women started to speak about being mocked, scolded, insulted and yelled at by health-care workers. Particularly sexist and offensive remarks were also reported. Testimonies from women in Honduras reported comments such as "you didn't cry when you did it, open your legs or your baby will die and it will be your fault". One health-care worker remarked to an adolescent girl giving birth, "you didn't shout when the penis was inside you, why do you shout now?" Women of lower socioeconomic status have described being humiliated by health workers for their poverty, for their inability to read or write, for residing in rural or slum areas or for being dirty or unkempt.³⁶ Women have also described experiencing threats of withholding treatment or of physical violence or poor outcomes by health-care providers during childbirth, including threats of beatings if they are non-compliant, and being blamed for their

³¹ See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4982443/>.

³² <https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/care-during-childbirth/care-during-labour-2nd-stage/who-recommendation-fundal-pressure-facilitate-childbirth>.

³³ Bohren et al. (2015), p. 17.

³⁴ See *Konovalova v. Russia*, No. 37873/04, European Court of Human Rights (2014).

³⁵ Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/31/57, para. 47.

³⁶ Information provided by indigenous women in the State of Guerrero, Mexico, included offensive comments and lack of understanding of traditional culture, which prescribes that women should not to bathe before childbirth to preserve the cold/warm balance of the body.

babies' or their own poor health outcomes. Such practices may cause psychological harm and suffering and may constitute psychological violence against women.

Informed consent

32. Informed consent for medical treatment related to reproductive health services and childbirth is a fundamental human right. Women have the right to receive full information about recommended treatments so that they can make informed and well-considered decisions. The International Federation of Gynecology and Obstetrics recognizes that the implementation of informed consent is an obligation even though it can be challenging and time consuming.³⁷ Lack of informed consent or its misuse was reported in the submissions sent by over 40 non-governmental organizations. As one non-governmental organization from Israel pointed out, a woman's consent is obtained for all interventions as soon as she enters the hospital, when she is asked to sign several forms. Such consent forms are in fact informed consent waivers, putting control in the hands of the medical team. Other consent forms, for procedures such as epidural analgesia and caesarean section, are usually presented to the woman while in labour, sometimes even during contractions, which makes it difficult for her to comprehend the information written on the form or to ask relevant questions. From this, it is evident that consent forms are often used as a substitute for the actual process of informed consent.³⁸

33. A German non-governmental organization recounted that according to Germany's patient law, full and informed consent is necessary for any type of care and treatment, but that the law is not respected. In reality, health-care providers are not trained to administrate informed consent according to the law.³⁹

34. A Swedish non-governmental organization described that the concept of woman-centred care is totally disregarded and informed choice and consent to treatment, concepts that were included in the Swedish law only in January 2015, have not yet been assimilated into the paternalistic medical culture that pervades the obstetric world. Routine treatments in hospitals such as the use of synthetic oxytocin injections after birth, cord blood testing or vitamin K shot are many times performed on women and their babies without asking for consent.⁴⁰

35. A non-governmental organization based in the United States of America reported that in most States it is legal for doctors and medical students to perform pelvic exams on unconscious women who are under anaesthesia for other treatment and who do not need pelvic exams and have not explicitly consented to one.⁴¹

36. A French non-governmental organization indicated that "the main issue at the core of obstetric violence is, in our opinion, the systematic deprivation of women's right to autonomy once they are in contact with a health-care facility. That deprivation can take many forms, going from the most obvious, such as the practice of an operation despite the lack of the women's consent, to some more insidious forms like

³⁷ International Federation of Gynecology and Obstetrics, *Ethical Issues in Obstetrics and Gynecology* (Guidelines regarding informed consent, p. 13), London, 2012.

³⁸ Submission of Sivan Lienhart Women Call for Birth ("Nashim Korot Laledet") to the Special Rapporteur, available at: <https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>.

³⁹ Submission of Motherhood e.V. to the Special Rapporteur, available at: <https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/Mother%20Hood%20e.V.pdf>.

⁴⁰ Submission of Födelsehuset to the Special Rapporteur, available at: <https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/F%3b6delsehuset.pdf>.

⁴¹ Submission of the Black Mamas Matter Alliance and the Center for Reproductive Rights to the Special Rapporteur, available at <https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/Black%20Mamas%20Matter%20Alliance%20and%20the%20Center%20for%20Reproductive%20Rights.pdf>.

the application of so-called ‘hospital protocols’ or the use of blank agreement forms that women are asked to sign, which allow the medical staff to do what they think is necessary without requiring any further consent”.⁴²

37. In its recent case the Committee on Economic, Social and Cultural Rights has concluded, in the context of fertility treatments, that the transfer of an embryo to a woman’s uterus without her informed consent constitutes a violation of her right to the highest attainable standard of health.⁴³

38. Informed consent is a process of ongoing communication and interaction between patient and provider, and a signature alone is not an indication of informed consent.⁴⁴ Providers need to be proactive in their provision of information. For consent to be valid, it must be voluntary and fully informed. The consent of the patient is needed regardless of the procedure, and consent can be withdrawn at any time under the patient-centred approach. Information should be provided in a manner and language that is understandable, accessible and appropriate to the needs of the individual making the decision. Educational level, physical or intellectual impairments and the age of the individual should be considered in determining the manner in which counselling and information is provided, and individual needs and preferences should be respected. Persons with disabilities should be provided with all the necessary support for making their decisions. Extreme caution must be exercised, especially in the case of individuals who have limited ways of being understood by others, to ensure that decisions that should be made using the process of supported decision-making are not de facto substituted decisions.⁴⁵

D. Root causes of mistreatment and violence against women in reproductive health services

Health systems conditions and constraints as structural causes of obstetric violence

39. In the context of maternal and reproductive healthcare, the conditions and constraints of the health system are the root causes of mistreatment and violence against women during childbirth. The poor working conditions of many health professionals and the historical overrepresentation of men in the gynaecological and obstetrical field is in contrast with the obligation of States to ensure the availability and quality of maternal health-care facilities, goods and services, the adequate training of providers and the gender balance of the health professionals. To fulfil this obligation, States “must devote the maximum available resources to sexual and reproductive health” and adopt a human rights-based approach to identifying budgetary needs and allocations.⁴⁶ However, many States have failed to prioritize women’s healthcare in their budgets. The failure of States to dedicate adequate

⁴² Submission of Make Mothers Matter to the Special Rapporteur available at: <https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>.

⁴³ Committee on Economic, Social and Cultural Rights, S.C. and G.P. v. Italy, Communication No. 22/2017, [E/C.12/65/D/22/2017](#), paras. 10.3 and 11.2.

⁴⁴ See Committee on the Elimination of Discrimination against Women, Views on Communication No. 4/2004, Ms. A.S. v. Hungary ([CEDAW/C/HUN/CO/6](#)); see also International Federation of Gynecology and Obstetrics, *Ethical Issues in Obstetrics and Gynecology* (Female contraceptive sterilization, p. 122), London, 2012.

⁴⁵ International Federation of Gynecology and Obstetrics, *Ethical Issues in Obstetrics and Gynecology* (Guidelines regarding informed consent, p. 13), London, 2012.

⁴⁶ Office of the United Nations High Commissioner for Human Rights (OHCHR), Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, [A/HRC/21/22](#), [A/HRC/21/22/Corr.1](#) and [A/HRC/21/22/Corr.2](#), pp. 4–8.

resources to women's specific health needs is a violation of women's right to be free from discrimination.⁴⁷ In addition, many States fail to ensure that health workers receive adequate training on medical ethics and patients' human rights, including the obligation of providers to provide respectful, non-discriminatory care.⁴⁸

40. Along with resource limitations, labour conditions within health systems can play a role in driving the mistreatment and violence against women during childbirth. A global survey of midwives carried out by WHO in 2016 revealed that "too often midwives report their efforts are constrained by unequal power relations within the health system. Many midwives also face cultural isolation, unsafe accommodation and low salaries".⁴⁹ Furthermore, health workers have explained that "health system issues – such as understaffing, high patient volume, low salaries, long hours, and the lack of infrastructure – [are relevant factors] creating stressful environments that facilitated unprofessional behaviour. The lack of support and supervision for health care providers has been found to contribute to low morale among providers and negative attitudes, which in turn perpetuate the mistreatment of women".⁵⁰

41. Additionally, health systems need to strengthen their response and assistance to women subjected to intimate partner violence or sexual violence, in line with the human rights instruments on gender-based violence against women and the WHO manual for health managers.⁵¹

Discriminatory laws and practices and harmful gender stereotypes

42. Some States have discriminatory national laws or practices that include spousal or third-party consent for women's medical treatments. This discriminates against women and replaces their choice over decision-making with that of a family member or other institutional authority. Such laws contribute to violence and mistreatment of women in reproductive health services.

43. Some women experience intersecting forms of discrimination, which have an aggravating negative impact, and gender-based violence may affect some women to different degrees, or in different ways; appropriate legal and policy responses are needed in this regard.⁵² For example, as one study from India concluded: "it is the cohort of poor, rural females delivering in public health facilities, undergoing vaginal births at [the] hands of providers other than doctors who are most at risk of experiencing [disrespect and abuse]. These are also the same females who are more at risk of maternal mortality".⁵³ The study found that the chances of experiencing

⁴⁷ See, for example, Committee on the Elimination of Discrimination against Women, *Alyne da Silva Pimentel Teixeira v. Brazil*, Communication No. 17/2008, CEDAW/C/49/D/17/2008, para. 7.6; and Committee on the Elimination of Discrimination against Women, general Recommendation No. 24, Women and health (article 12 of the Convention) (1999).

⁴⁸ WHO statement, "The prevention and elimination of disrespect and abuse during facility-based childbirth", WHO/RHR/14.23 (2015).

⁴⁹ WHO, International Confederation of Midwives, White Ribbon Alliance, joint news release, "WHO and partners call for better working conditions for midwives" (13 October 2016) (<https://www.who.int/en/news-room/detail/13-10-2016-who-and-partners-call-for-better-working-conditions-for-midwives>).

⁵⁰ Bohren et al. (2015), pp. 14 and 20.

⁵¹ WHO, *Responding to intimate partner violence and sexual violence against women; WHO clinical and policy guidelines*, Geneva, 2013; and WHO, *Strengthening health systems to respond to women subjected to intimate violence or sexual violence: A manual for health managers*, Geneva, 2017.

⁵² Committee on the Elimination of Discrimination against Women, General recommendation No. 28, para. 12.

⁵³ T. Nawab, U. Erum, A. Amir, N. Khaliq, M. A. Ansari, A. Chauhan, "Disrespect and abuse during facility-based childbirth and its sociodemographic determinants – A barrier to healthcare utilization in rural population", *Journal of Family Medicine and Primary Care*, vol. 8, 2019; pp. 239–245.

disrespect and abuse were 3.6 times higher among females with low socioeconomic status.⁵³

44. Forced sterilization is an example of intersectional discrimination often targeting women belonging to a minority and indigenous women. Some maternity hospitals have adopted discriminatory practices of segregating women within facilities based on race or ethnicity. For example, Roma women in Slovakia are placed in designated “Roma-only” rooms, which are often over-crowded, and the hospital may force Roma women to sleep two to a bed or place their beds in the hallway.⁵⁴

45. Women and girls with disabilities experience discrimination based on multiple aspects of their identity, including gender and disability.⁵⁵ They are very often perceived as asexual or sexually inactive. The Special Rapporteur on the rights of persons with disabilities has also noted: “girls and young women with disabilities are frequently pressured to end their pregnancies owing to negative stereotypes about their parenting skills and eugenics-based concerns about giving birth to a child with disabilities”.⁵⁶

46. Harmful gender stereotypes in reproductive health context on women’s decision-making competence, women’s natural role in society and motherhood limit women’s autonomy and agency. These stereotypes arise from strong religious, social and cultural beliefs and ideas about sexuality, pregnancy and motherhood.⁵⁷ These harmful stereotypes are further justified by the belief that childbirth is an event that requires suffering on the part of the woman. Women are told to be happy about a healthy baby – their own physical and emotional health is not valued.

47. The Human Rights Committee recognized in *Mellet v. Ireland* that gender stereotypes require that “women should continue their pregnancies regardless of the circumstances, their needs and wishes, because their primary role is to be mothers and caregivers.”⁵⁸

48. The International Federation of Gynecology and Obstetrics has developed guidelines on “Harmful stereotyping of women in health care” (2011) that note the nature and impact of harmful stereotyping in the provision of care to women and offer specific guidance for providers across the globe on how to avoid negative stereotyping in the provision of health care.⁵⁹

Power dynamics and the abuse of the doctrine of medical necessity

49. Power dynamics in the provider-patient relationship are another root cause of mistreatment and violence, which are compounded with gender stereotypes on role of women. The health provider has the power of authoritative medical knowledge and the social privilege of medical authority,⁶⁰ while the woman is largely dependent on

⁵⁴ Center for Reproductive Rights, *Vakeras Zorales – Speaking Out: Roma Women’s Experiences in Reproductive Health Care in Slovakia* (2017), p. 13 (<https://reproductiverights.org/sites/default/files/webform/GLP-SlovakiaRomaReport-Final-Print.pdf>).

⁵⁵ See, for example, the report of the Special Rapporteur on the rights of persons with disabilities on the sexual and reproductive health and rights of girls and young women with disabilities, [A/72/133](#), para. 21.

⁵⁶ *Ibid.*, para. 31.

⁵⁷ Rebecca J. Cook and Simone Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (Philadelphia, University of Pennsylvania Press, 2010), p. 34.

⁵⁸ Human Rights Committee, *Mellet v. Ireland*, Communication No. 2324/2013, [CCPR/C/116/D/2324/2013](#), para. 3.19.

⁵⁹ International Federation of Gynecology and Obstetrics, *Ethical Issues in Obstetrics and Gynecology* (Harmful stereotyping of women in health care, p. 28), London, 2012.

⁶⁰ See Joanna N. Erdman, “Commentary: Bioethics, Human Rights and Childbirth”, *Health and Human Rights Journal*, 17/1, June 2015.

the provider for information and care. A woman during childbirth is also particularly vulnerable. Although providers do not necessarily have the intention of treating their patients badly, “medical authority can thus foster a culture of impunity, where human rights violations do not only go unremedied, but unnoticed”.⁶⁰ This power imbalance is particularly apparent in instances in which providers abuse the doctrine of medical necessity in order to justify mistreatment and abuse during childbirth.

E. Application of the international and regional human rights framework to mistreatment and violence in reproductive health services

50. Violence against women as a human rights violation and as a form of discrimination against women is prohibited by Convention of the Elimination of All Forms of Discrimination against Women, the International Declaration on the Elimination of Violence against Women, the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention), the Programme of Action of the International Conference on Population and Development and the Platform of Action of the Fourth World Conference on Women.

51. In addition to these human right instruments in 2015, States Members of the United Nations adopted the 2030 Agenda for Sustainable Development, in which they committed themselves to the achievement of the goals of healthy lives and well-being for all at all ages (Goal 3) and gender equality and the empowerment of all women and girls (Goal 5) by ending all forms of discrimination against all women and girls everywhere” (target 5.1) and eliminating all forms of violence against all women and girls in the public and private spheres (target 5.2),⁶¹ thus ensuring access to quality maternal healthcare and guaranteeing women’s and girls’ reproductive autonomy.

52. In 2015, several United Nations and regional human rights experts, including the Special Rapporteur, issued a joint statement on the implementation of the 2030 Agenda, calling on States to “address acts of obstetric and institutional violence suffered by women in health care facilities” and “to take all practical and legislative measures to prevent, prohibit, and punish such acts and guarantee redress”.⁶²

Women’s right to the highest attainable standard attainable of physical and mental health

53. The right to health is enshrined in the constitution of WHO, in the Universal Declaration on Human Rights and in other human rights instruments, notably in the

⁶¹ Resolution 70/1.

⁶² Joint statement by United Nations experts in the field of human rights on the 2030 Agenda for Sustainable Development(Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Special Rapporteur on the situation of human rights defenders; Special Rapporteur on violence against women, its causes and consequences, and Chair of the Working Group on discrimination against women in law and in practice), experts of the African Commission on Human and Peoples’ Rights (Special Rapporteur on Human Rights Defenders and Focal Point on Reprisals in Africa and Special Rapporteur on Rights of Women in Africa) and expert of the Inter-American Commission on Human Rights (Rapporteur on the Rights of Women) (<https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16490&LangID=E>).

Beijing Platform for Action, which establishes that women's rights include their right to "sexual and reproductive health, free of coercion, discrimination and violence".⁶³

54. Furthermore, the Declaration on the Elimination of Violence against Women and the Convention on the Elimination of All Forms of Discrimination against Women, in conjunction with general recommendations 19 and 35 of the Committee on the Elimination of Discrimination against Women, uphold women's right to the highest standard attainable of physical and mental health. Article 12 of the Convention recommends that States guarantee women "appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary" while in general recommendation 24 the Committee recognized that some medical procedures are needed only by women and "require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice".⁶⁴

55. International human rights treaty bodies and independent experts or the special procedures of the Human Rights Council have focused on a significant number of women's human rights violations in reproductive health service and have analysed the range of abuses that women experience during childbirth, including the context in which they occur, and have found violations, inter alia, of the rights to health, life, privacy, freedom from discrimination, freedom from inhuman and degrading treatment and effective remedy.

56. For the first time, in the case of *Alyne da Silva Pimentel Teixeira v. Brazil*, the Committee on the Elimination of Discrimination against Women found a Government accountable for a maternal preventable death. The case concerned a woman of Afro-Brazilian descent who died from obstetric complications after being denied quality maternal health care in both private and public health-care facilities. The Committee recognized that these violations reached system-level factors of neglect, including the inadequate resources and ineffective implementation of State policies, and underscored that the failure "to meet the specific, distinctive health needs and interests of women not only constitutes a violation of article 12, paragraph 2, of the Convention, but also discrimination against women under article 12, paragraph 1, and article 2 of the Convention".⁶⁵

57. In a communication regarding cases of violence against women during childbirth and other reproductive health services in Croatia, the Special Rapporteur on violence against women, along with the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the Working Group on the issue of discrimination against women in law and practice called on the Government "to conduct an independent investigation into those allegations, to publish its results and to elaborate a national action plan for women's health" to ensure accountability for the abuses experienced by women.⁶⁶

58. In an inquiry against the United Kingdom of Great Britain and Northern Ireland, the Committee on the Elimination of Discrimination against Women clarified that a criminal law that "compels women in cases of severe fetal impairment, including fatal fetal abnormality, and victims of rape or incest to carry pregnancies to full term,

⁶³ *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, annex II. 6.

⁶⁴ Committee on the Elimination of Discrimination against Women, general recommendation No. 24, women and health (article 12) (1999), para. 31(e).

⁶⁵ Committee on the Elimination of Discrimination against Women, *Alyne da Silva Pimentel Teixeira v. Brazil*, Communication No. 17/2008, CEDAW/C/49/D/17/2008, para. 7.6.

⁶⁶ See <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=24198&LangID=E>. The previous Special Rapporteur, in her 2013 report, expressed concern about the shackling of pregnant women during labour and delivery, A/68/340, para. 57.

thereby subjecting them to severe physical and mental anguish”, constitutes gender-based violence against women.⁶⁷ It further found that such restriction from exercising reproductive choice, affecting only women, resulted in women being forced to carry almost every pregnancy to full term, involves mental or physical suffering, constitutes violence against women and potentially amounts to torture or cruel, inhuman and degrading treatment, in violation of articles 2 and 5, read with article 1, of the Convention on the Elimination of All Forms of Discrimination against Women.

59. In the case *L.C v. Peru*, the Committee on the Elimination of Discrimination against Women ruled that Peru must amend its law to allow women to obtain an abortion in cases of rape and sexual assault, establish a mechanism to ensure the availability of those abortion services and guarantee access to abortion services when a woman’s life or health is in danger – circumstances under which abortion is currently legal in the country.⁶⁸ A similar decision has been adopted by the Human Rights Committee in the case of *K.L v. Peru*.⁶⁹ The findings of the Committee were reaffirmed, almost 15 years later, in the case *Mellet v. Ireland*.⁵⁸

60. In 2018, the Special Rapporteur issued a joint statement, with the Committee of Experts of the Follow-up Mechanism to the Belém do Pará Convention, urging the Government of El Salvador to release Imelda Cortez, a woman who was being held in prison pending a criminal trial because of an obstetric emergency. In the statement, both parties expressed their deep concern for imprisoned women seeking emergency obstetric health services, including due to miscarriages, and who did not receive them as a result of laws that criminalize abortion and prevent doctors from providing medical support.⁷⁰

61. The Committee on the Elimination of Discrimination against Women has also found that denying women access to modern forms of contraception constitutes discrimination against women, violates their rights to health services and information and to decide the number and spacing of their children, and perpetuates harmful gender stereotypes that impede equality in the health sector.⁷¹

62. Regional human rights bodies have also addressed issues of mistreatment during childbirth. The European Court of Human Rights has found violations of the rights to private life and to be free from torture or inhuman or degrading treatment in cases concerning childbirth.⁷² These include cases on forced sterilization during childbirth,⁷³ the removal of a newborn from the mother’s care without consent or a health-related justification⁷⁴ and a medical intervention carried out on a pregnant woman without her informed consent.⁷⁵

⁶⁷ Committee on the Elimination of Discrimination against Women, Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, [CEDAW/C/OP.8/GBR/1](#), para. 83 (a).

⁶⁸ Committee on the Elimination of Discrimination against Women, *L.C. v. Peru*, Communication No. 22/2009, [CEDAW/C/50/D/22/2009](#).

⁶⁹ *K.L. v. Peru*, Communication No. 1153/2003, [CCPR/C/85/D/1153/2003](#) (2005).
https://www.ohchr.org/Documents/Issues/Women/SR/StatementMESECVI_EN.pdf.

⁷¹ Committee on the Elimination of Discrimination against Women, *Summary of the inquiry concerning the Philippines under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*, UN Doc. [CEDAW/C/OP.8/PHL/1](#) (2015), (denial of access to contraception in Manila).

⁷² *Konvalova v. Russia*, No. 37873/04, European Court of Human Rights (2014).

⁷³ *V.C. v. Slovakia*, No. 18968/07, European Court of Human Rights, (2012); *N.B. v. Slovakia*, No. 29518/10, European Court of Human Rights (2012); *I.G. and Others v Slovakia*, Application no. 15966/04, European Court of Human Rights (2012).

⁷⁴ *Hanzelkovi v Czech Republic*, No. 43643/10, European Court of Human Rights (2015).

⁷⁵ *Csoma v Romania*, No. 8759/05, European Court of Human Rights (2013).

63. The European Court of Human Rights specifically addressed women's right to privacy during birth in the case of *Konovalova v. Russia* case.⁷² During labour, despite Ms. Konovalova's objections, a group of medical students observed the birth in the delivery room and related interventions, including an episiotomy, and were given information about her health and medical treatment. Relevant domestic law provided that medical students could assist in medical procedures under supervision, but made no provision for obtaining patients' informed consent. The European Court of Human Rights found a violation of article 8, which states that: "Everyone has the right to respect for his private and family life" and that "There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society".

64. The European Court of Human Rights in the 2010 in the case of *Ternovszky v. Hungary*, recognized that Hungary's lack of comprehensive and effective regulation of home birth, which exposed health care professionals who performed home births to the risk of prosecution, amounted to a violation of the right to private life because it effectively denied the applicant the opportunity to give birth at home. Noting that the woman "is entitled to a legal and institutional environment that enables her choice," the Court concluded that the "lack of legal certainty and the threat to health professionals has limited the choices of the applicant considering home delivery",⁷⁶ amounting to a violation of her private life, as protected by article 8 of the European Convention.

65. In contrast, in the case of *Dubská and Krejzová v. the Czech Republic*,⁷⁷ the Court found that Czech legislation prohibiting midwives' attendance at home births did not interfere with women's right to private life under article 8. Similarly, in *Pojatina v. Croatia*,⁷⁸ the Court found that the prohibition of home birthing in Croatian law does not violate article 8.

66. The Inter-American Court of Human Rights found violations of the rights to personal integrity, personal freedom, private and family life, access to information and to be free from cruel, inhuman and degrading treatment, in a case concerning the involuntary sterilization of a woman in a public hospital in the Plurinational State of Bolivia during a caesarean section.⁷⁹ In addition, the Inter-American Commission has issued a statement urging "States to document, investigate, and punish emerging forms of violence against women, girls and adolescents", including obstetric violence.⁸⁰

67. The African Commission on Human and Peoples' Rights has issued a Resolution on Involuntary Sterilization and the Protection of Human Rights in access to HIV Services.⁸¹

68. In a significant number of human rights cases addressing violence and discrimination of women in reproductive health services, as well as in recommendations from human rights treaty bodies and special procedures, human

⁷⁶ *Ternovszky v. Hungary*, No. 67545/09, European Court of Human Rights (2011), para. 26;

⁷⁷ *Dubská and Krejzová v. the Czech Republic*, Application Nos. 28859/11 and 28473/12, European Court of Human Rights (2016).

⁷⁸ *Pojatina v Croatia*, Application No., 18558/12, European Court of Human Rights (2018).

⁷⁹ *I.V. v. Bolivia*, Preliminary Objections, Merits, Reparations and Costs, Judgment, Inter-American Court of Human Rights (ser. C) No. 329 (2016).

⁸⁰ Inter-American Commission on Human Rights, press release, *On International Women's Day, the IACHR Urges States to Refrain from Adopting Measures that Would Set Back Respect for and Protection of Women's Rights* (8 March 2018) (http://www.oas.org/en/iachr/media_center/PReleases/2018/044.asp).

⁸¹ African Commission on Human and Peoples' Rights, Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services (2013) (<http://www.achpr.org/sessions/54th/resolutions/260/>).

rights standards that States should follow have already been identified. Many of the recommendations are applicable to other similar cases of mistreatment and obstetric violence and should be used by all States for the prevention of gender-based violence against women and for the protection of women's right to the highest attainable physical, mental and reproductive health.

F. Actions taken at the national level to address the mistreatment and violence against women during facility-based childbirth

69. Some Governments have introduced laws and other initiatives to address the mistreatment and violence against women during childbirth, including training for health-care providers. In recent years, many States have passed laws or issued policies and good practices that expressly allow a woman to be accompanied by a companion of her choice during childbirth and have developed broader legislation encouraging the “humanization” of childbirth. Nevertheless, even when such laws exist, women have reported receiving a blank denial of their requests for a companion of their choice in the delivery room.⁸²

70. Broader legislation encouraging the humanization of childbirth has also been adopted in Argentina and Brazil. Argentina's law “explicitly emphasizes the rights of women, newborns, birth companions and families.”⁸³

71. In 2015, the National Health Services of the United Kingdom commissioned a review of maternity services, partly in response to an “investigation into the serious failings in maternity services”, which set out key lesson for the benefit of maternity services as a whole.⁸⁴ The report included findings and recommendations for various actors to improve the quality of maternal health services, in particular the creation of a “national standardized investigation process [for] when things go wrong”; developing indicators and benchmarks to improve the quality of maternity services.”⁸⁵

72. In some countries in Latin America, “women's groups and networks, feminists, professional organizations, international and regional bodies and public health agents and researchers” have led a movement around “obstetric violence” to improve the quality of care that women receive during pregnancy, childbirth and the postpartum period. This new movement “specifically locates ‘obstetric violence’ at the nexus of gender-based violence and clinical malpractice, and interweaves elements of both respectful treatment and quality care”. Argentina (2009), Mexico (2014), Panama (2013), Suriname (2014) and Venezuela (Bolivarian Republic of) (2007) have passed laws criminalizing obstetric violence.⁸³

73. The Plurinational State of Bolivia has passed a law on violence within health-care services, with a “special focus on pregnant and childbearing women. In addition, the law defines a new term, ‘violence against reproductive rights’ that extends beyond the definitions of obstetric violence provided by Argentina and the Bolivarian Republic of Venezuela to include miscarriage and breastfeeding.”⁸³

⁸² Janka Debrecéniová, ed., *Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia, Citizen, Democracy and Accountability* (2015); see also Tamar Kabakian-Khasholian, et al. “Implementation of a labour companionship model in three public hospitals in Arab middle-income countries”, *Acta Paediatrica*, 20 December 2018 (<https://onlinelibrary.wiley.com/doi/full/10.1111/apa.14540>); see also Bohren et al. (2015)

⁸³ See C.R. Williams, C. Jerez, K. Klein, M. Correa, J. M. Belizán, G. Cormick, “*Obstetric violence: a Latin American legal response to mistreatment during childbirth*”, *BJOG, An International Journal of Obstetrics and Gynaecology*, 2018.

⁸⁴ National Maternity Review, *Better Births: Improving outcomes of maternity services in England, A Five Year Forward View for maternity care* (2016), p. 31.

⁸⁵ *Ibid.*, pp. 10–11.

74. Although some of the countries mentioned above have passed progressive laws on obstetric violence, access to safe abortion and other reproductive health services remains a challenge, and progress on maternal care has not necessarily been accompanied by progress in other areas of women's sexual and reproductive rights.

IV. Conclusion and recommendations for States and other stakeholders

75. States have an obligation to respect, protect and fulfil women's human rights, including the right to highest standard attainable of physical and mental health during reproductive services and childbirth, free from mistreatment and gender-based violence, and to adopt appropriate laws and policies to combat and prevent such violence, to prosecute perpetrators and to provide reparations and compensation to victims.

76. Women's human rights include their right to receive dignified and respectful reproductive health-care services and obstetric care, free from discrimination and any violence, including sexism and psychological violence, torture, inhuman and degrading treatment and coercion. In the context of reproductive care and childbirth, health systems must have the necessary budgetary resources needed to provide quality, accessible reproductive and maternal healthcare, thus ensuring that women's reproductive health needs and interests are met during childbirth, gynaecological examinations, fertility treatments, miscarriage, abortion, contraception and in other sexual and reproductive health contexts.

77. States should address the current problem of mistreatment and violence against women in reproductive services and childbirth from a human rights perspective and use it to conduct an independent investigation into women's allegations of mistreatment and gender-based violence in health-care facilities, which should include structural and systematic causes, including stereotypes on the role of women role in society, and should publish the results and recommendations, which should be used to revise laws, policies and national action plans on reproductive health.

78. States should establish constructive cooperation between health institutions and professional associations with women's non-governmental organizations, women's movements and independent human rights institutions dealing with reproductive and obstetric care.

79. States should also elaborate national strategies on reproductive health services and childbirth in order to secure respectful and caring human rights-based treatments in the context of childbirth and other reproductive services, in line with international women's human right standards, including respect for privacy and confidentiality.

80. States should address: (a) structural problems and underlying factors within reproductive health-care systems that reflect discriminatory socioeconomic structures ingrained in societies; (b) the lack of proper education and training on women's human rights for all health professionals; (c) the lack of qualified staff and the resultant heavy workloads in health-care facilities; and (d) budgetary constraints. States should allocate adequate funding, staffing and equipment for maternity care wards and facilities, in line with international human rights law, which requires that States devote the maximum available resources to sexual and reproductive health, including maternal health and childbirth programmes.

Informed consent

81. To combat and prevent mistreatment and violence against women, States should:

- (a) Ensure the effective and proper application of informed consent, in line with human rights standards;**
- (b) Adopt effective health laws and policies for the application of informed consent in all reproductive health services and guarantee prior, free and informed consent for caesarean sections, episiotomies and other invasive treatments during childbirth;**
- (c) Respect women's autonomy, integrity and their capacity to make informed decisions about their reproductive health;**

Prevention of obstetric violence

- (d) Guarantee women's right to a birth companion of her choice in law in practice;**
- (e) Consider the possibility of allowing home birth and avoiding the criminalization of home birth;**
- (f) Monitor health-care facilities and collect and publish data on the percentage of caesarean sections, vaginal births and episiotomies and on other treatments related to childbirth, obstetric care and reproductive health services on a yearly basis;**
- (g) Apply women's human rights instruments and WHO standards related to respectful maternity care, intrapartum care and violence against women;**
- (h) Address the lack of anaesthesia and pain relief, lack of choice of birth position and lack of respectful care;**

Accountability

- (i) Establish human rights-based accountability mechanisms to ensure redress for victims of mistreatment and violence, including financial compensation, acknowledgement of wrongdoing, formal apology, and guarantees of non-repetition;**
- (j) Ensure professional accountability and sanctions by professional associations in cases of mistreatment and access to justice in cases of human rights violations;**
- (k) Guarantee full and fair investigations into allegations of mistreatment and violence against women during childbirth;**
- (l) Ensure that women victims of violations are provided with adequate remedies, which may take the form of restitution, financial compensation, satisfaction or guarantees of non-repetition;**
- (m) Ensure that regulatory bodies, including national human rights institutions, ethic commissions and ombudspersons and equality bodies have the mandate and resources to exercise oversight over public and private birthing facilities to guarantee respect for women's autonomy and privacy;**
- (n) Raise awareness among lawyers, judges and the public about the women's human rights in the context of childbirth to ensure the effective use of remedies;**

Discriminatory laws and harmful gender stereotypes

(o) Review and strengthen laws that prohibit all forms of mistreatment and violence against women, including psychological violence, during pregnancy and childbirth and other reproductive health services in line women's human rights instruments;

(p) Abolish any mandatory husband, relative or similar authorization for reproductive health services which concerns women;

(q) Repeal laws which criminalize abortion in all circumstances, remove punitive measures for women who undergo abortion, and at the very minimum, legalize abortion in cases of sexual assault, rape, incest, and when the continued pregnancy endangers the mental and physical health of the woman or the life of the woman, and provide access to safe, quality post-abortion care;

(r) Remove criminal charges and imprisonment of women who have been seeking emergency obstetric health services, including due to miscarriages, and remove punitive measures against doctors in order to enable them to provide the needed medical support;

(s) Prohibit and address practice of forced sterilization procedures, especially with respect to women belonging to a minority and indigenous women, improve safeguards against such human rights violations and provide appropriate redress and compensation for victims;

(t) Address the intersectional discrimination or compounded stereotypes experienced by subgroups of persons.

International organizations

82. In line with WHO statements and through the application of human rights-based standards, WHO, the Office of the United Nations High Commissioner for Human Rights, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), UNFPA and regional organizations should strengthen their role in combating and preventing mistreatment and violence during reproductive health services and childbirth. In this regard, they should increase cooperation between themselves and with independent women's human rights mechanisms such as the Committee on the Elimination of Discrimination against Women, the Special Rapporteur of the Human Rights Council on violence against women, its causes and consequences, the Follow-up Mechanism to the Belém do Pará Convention, the Group of Experts on Action against Violence against Women and Domestic Violence of the Council of Europe, the Special Rapporteur on the Rights of Women in Africa of the African Commission on Human and Peoples' Rights, the Rapporteur of the Inter-American Commission on Human Rights on the Rights of Women, as well as with States, non-governmental organizations and independent institutions in preventing such violence and upholding women's human right to the highest attainable standards of physical, mental and reproductive health.