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Gynecological and Obstetric Violence: Framing the Phenomenon under International Human Rights Law

Abstract: The purpose of this chapter is to frame the issue of gynecological and obstetric violence from a human rights law perspective. Considering the lack of a comprehensive legally binding definition, this contribution serves as a starting point to reflect further on the notion and enhance scholarly debate on the matter. Ultimately, it argues in favor of the recognition of gynecological and obstetric violence as a form of gender-based violence, positing that attempts at drafting a definition should embrace a human rights-based and intersectional approach focused on the gendered element.

1 Introduction

Despite the growing attention, at the international and regional levels, devoted to gynecological and obstetric violence, the phenomenon remains undefined from a legal perspective. Though a few notable attempts at providing a legal definition can be accounted for in domestic legal systems, the international legal system and in particular human rights law have not yet been able to fill such legal void. The purpose of this chapter is to address the issue of gynecological and obstetric violence from a human rights perspective, deconstructing the phenomenon and evaluating its impact on the human right to freedom from inhuman or degrading treatment, on women's right to sexual and reproductive health and on the right to be free from discrimination. It also acknowledges that gynecological and obstetric violence is based on, and perpetuates, gender stereotyping. Far from being able to provide a comprehensive legally binding definition within these pages, this contribution serves as a starting point to foster discussion on the matter, arguing in favor of the recognition of gynecological and obstetric violence as a form of gender-based discrimination which can lead to gender-based violence against women. Furthermore, it contends that attempts at a definition should embrace a human rights-based and intersectional approach.[1]

1 This contribution focuses on the impact of gynaecological and obstetric violence on women's rights. Nonetheless, it should be acknowledged that, as a phenomenon deeply rooted in gender stereotypes, it can affect non-binary and trans people as well.

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2 Unveiling the complex nature of gynecological and obstetric violence

As Pickles (2022, 632) warns, "naming is not a neutral phenomenon," and "violence" is certainly not a neutral term. The choice of terminology, especially concerning the word "violence," has sparked lively debates, with health professionals opposing it strongly, on the one side, and some victims, on the other side, who would use words such as "torture" and "dehumanization" to describe what they have experienced. Framing the "negligent care, omissions, indirect causing of harm, and physical and psychological harms too" (Pickles 2022, 632) taking place in the wider context of sexual and reproductive health services as a form of violence can prove effective. However, there are some challenging aspects to consider. Pickles notes that, at times, women and childbearing persons who have suffered from it struggle to put a name to their experience or do not perceive it as a form of violence (Pickles 2024). The term "violence" is also opposed, as mentioned, by healthcare professionals, who refrain from naming these practices as a form of violence. A more nuanced and careful approach was also adopted by the World Health Organization (WHO), which in 2015 released a statement concerning the "disrespect and abuse" spreading— across facility-based childbirth (WHO 2015). Speaking about violence may lead to the related perception of individuals who have experienced it as *mere victims*, perpetuating conceptions of helplessness and pity towards them which exacerbate stereotypes and their condition of vulnerability.

However, there is power in naming what one has suffered. There is power in recognizing that even though what individuals have experienced is a form of violence, they survived it, reclaiming their own agency in the process. There is also power in realizing that others have suffered what you have, and that the experience of violence does not lead to being a mere victim. The importance of recognizing the form of violence in gender-based phenomena puts the spotlight — especially from an international human rights law perspective — on the inaction of the State in addressing such phenomena (De Vido 2021). It also gives voice to those who have been subjected to practices embedded in social stigma — such as gynecological and obstetric violence — and highlights the lack of consent which underlies any act of violence suffered. From an international legal perspective, it also situates the conduct of the State in the realm of violence against women and characterizes it as a serious violation of women's human rights. According to Pickles: "'Obstetric violence' [...] reflects an 'epistemic intervention' [...] that forces us to confront the fact that the gynaecologist's office or the birthing room are not separate spheres removed from societal relations of power, human rights violations, legacies of colonialisation, and systemic prejudices" (Pickles 2022, 632).

In April 2024, upon request of the FEMM Committee of the European Parliament (EP) — the Committee on Women's Rights and Gender Equality — a report was issued titled *Obstetric and Gynaecological Violence in the European Union (EU): Prevalence, legal frameworks and education guidelines for prevention and elimination* (Brunello and others 2024). The report, authored by several researchers, aims to provide an overview of how the phenomenon of gynecological and obstetric violence occurs across the 27 Member States of the European Union, of the level of understanding and the awareness of the issue and, significantly, of how the domestic legal system of EU Member States frame it. The authors describe gynecological and obstetric violence as a form of gender-based violence and recognize that, despite the difficulty in accessing and collecting data on the issue from the EU Member States, gynecological and obstetric violence is found across the EU (Brunello and others 2024, 9–12).

What emerges from the report is that gynecological and obstetric violence is neither new, nor recent, and that every Member State is affected by it. Women throughout the EU have experienced and continue to experience gynecological and obstetric violence. Despite its overall scope, awareness is still developing, mainly thanks to the contributions of scholars from several disciplines as well as of efforts to define the notion.[2] One of the reasons why it is difficult to pinpoint this phenomenon is indeed the lack of a widely accepted (and legally binding) definition. The absence of an agreed-upon notion — not only at domestic level but also at the regional and international levels — has detrimental effects both on the victims, who struggle to correctly identify their experiences, and on potential perpetrators, including health professionals, who might fail to understand how to avoid engaging in gynecological and obstetric violence-related behaviors.

Gynacological and obstetric violence is a complex phenomenon, rooted in the patriarchal structure of societies as well as in medicine and in the medical sector, "a systemic problem of institutionalized gender-based violence" (Diaz-Tello 2016, 1). The Council of Europe (CoE) Rapporteur for the Committee on Equality and Non Discrimination stated that it "is the result of the continued existence of a patriarchal culture within the medical sector, particularly in the training given to health care staff, and of persistent gender stereotypes in society" (Blondin 2019). According to the FEMM Committee Report: "as a social and systemic phenomenon, obstetric and gynaecological violence is situated at the convergence of two structural crises: discrimination based on gender and the under-resourcing of healthcare systems and institutions" (Brunello and others 2024). Both attempts to address the roots of

2 Among scholarly contributions to the phenomenon of gynecological and obstetric violence, see: Pickles and Herring 2019; Chadwick 2023; Diaz-Tello 2016; García Moreno and Heidari 2016; Kukura 2018; Perrotte 2010; Pickles 2022; Quattrocchi 2019; Bernardini and Dal Monico 2024.

gynecological and obstetric violence share two characteristics: first, the finding that this phenomenon is deeply rooted in gender stereotypes — it is a form of gender-based discrimination and violence — and second, that it involves the medical or healthcare field, meaning it is experienced in a specific context that can exacerbate women's vulnerable condition.

Though the "where" and the "who" of gynecological and obstetric violence can be identified, one more aspect contributes to the difficulty of pinpointing the phenomenon. Both the FEMM Committee Report and the Report of the Rapporteur for the Committee on Equality and Discrimination refer to it as gynecological and obstetric violence. The 2024 Case Study Analysis conducted on four EU Member States by several authors for the European Commission on the issue speaks of obstetric violence (Rozée and others 2024). In this essay, the expression "gynecological and obstetric violence" is preferred to the more common expression "obstetric violence," because it is an umbrella term able to convey the multi-faceted and complex nature of the phenomenon, which extends this form of violence to all reproductive health-services, whereas obstetric violence may allude to experiences more centered around childbirth (Pickles 2024, 616).[3] It hence may not address similar forms of violence which happen in the wider context of reproductive healthcare services, such as abortion. Gynecological and obstetric violence does not only occur in the delivery room, but indicates a much more complex pattern of abuse, both physical and verbal, occurring before, during and after a pregnancy, in the wider context of reproductive and sexual health-related services (Bernardini and Dal Monico 2024).

2.1 Looking for a definition: international, regional and national efforts

At the international level within the UN context, gynecological and obstetric violence was acknowledged by both the WHO and the Special Rapporteur on Violence against Women in the report on a human-rights based approach to mistreatment and violence against women in reproductive health services. The latter defines obstetric violence as: "the kind of violence experienced by women during facility-based childbirth" (Šimonović 2019). The WHO also addressed the issue of the widespread mistreatment of women during childbirth in medical facilities in its 2015 statement by condemning the practice and framing it as a violation of their

3 The definition provided by Pickles refers to obstetric violence as a social phenomenon and as violence and abuse during childbirth. However, many women refer to abortion-related gynaecological and obstetric violence.

rights to life, health and bodily integrity as well as freedom from discrimination (WHO 2015). Alongside physical abuse, WHO included the "profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilisation)" (WHO 2015), as well as lack of confidentiality and of fully informed consent.

At the regional level, attempts at tackling gynecological and obstetric violence can be found in reports[4] and soft law and only partially in a hard law instrument. The 2011 Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence includes the criminalization of female genital mutilation (Art. 38) and of forced abortion and forced sterilization (Art. 39).[5] Though not expressly recognized as forms of gynecological and obstetric violence and only scratching the surface of such a complex and multi-faceted phenomenon, three relevant practices have been included in a hard law instrument as forms of violence against women which States are under an obligation to criminalize. Among soft law instruments, it is worth mentioning Resolution 2306(2019) adopted by the Parliamentary Assembly of the Council of Europe (PACE), which explicitly refers to gynecological and obstetric violence and defines it as "a form of violence that has long been hidden and is still too often ignored" (PACE 2019), hinting at the social stigma that still surrounds the issue and stressing its non-consensual nature. Although the Resolution does not provide a definition, it calls on the Member States of CoE to take measures to address gynecological and obstetric violence-related behaviors within their healthcare systems, both public and private. Gynecological and obstetric violence was also partially tackled by Resolution 2020/2215(INI) of the European Parliament, though aimed at addressing the broader issue of sexual and reproductive health rights in the EU. Among the measures specifically aimed at tackling gynecological and obstetric violence, the European Parliament invites Member States to act by "reinforcing procedures that guarantee respect for free and prior informed consent and protection from inhuman and degrading treatment in healthcare settings" (EP 2022) and calls on the European Commission to take action concerning this specific form of violence against women.

Some notable efforts can be found in national legal systems, with Latin American countries being forerunners in criminalizing obstetric violence in domestic legislations. One initial significant attempt at framing this form of violence was made at the Conference on the Humanization of Childbirth held in Fortaleza, Brazil, in 2000, where 12 Latin American countries met and funded the RELACAHUPAN–Red Latino-

4 Obstetric violence was mentioned by the Follow-Up Mechanism established under the Convention on the Prevention, Punishment and Eradication of Violence against Women (MESECVI) in 2012. See OAS MESECVI 2012.

5 See also Alaattinoğlu 2023; Mestre i Mestre 2023.

americana y del Caribe para la Humanización del Parto y Nacimiento: a network and platform for activists, researchers and healthcare providers to meet and discuss child-birth related issues.[6] A few years later, in 2007, building on the achievements of the Conference, Venezuela passed the Organic Law on Women's Right to a Violence-free Life, which included the first legally binding definition of obstetric violence (not *gynecological* and obstetric violence). According to Venezuelan law, obstetric violence can be defined as:

> The appropriation of a woman's body and reproductive processes by health personnel, in the form of dehumanising treatment, abusive medicalization and pathologization of natural processes, involving a woman's loss of autonomy and of the capacity to freely make her own decisions about her body and her sexuality, which has negative consequences for a woman's quality of life (OAS MESECVI 2012).

Two years later, Argentina adopted Law No. 26.485 – "Ley de Proteccion Integral A Las Mujeres." The article provides a list of forms of violence against women and in Article 6, letter e), it includes a definition of obstetric violence. In 2018, Uruguay amended its civil and criminal code by adopting a reform of Law No. 17.514 on violence against women based on gender. The previous law, which dated back to 2002, was amended by Law No. 19580, expanding the criminalized forms of gender-based violence against women to include gynecological and obstetric violence, providing a definition focused on women's loss of autonomy on decisions concerning their own body.[7]

Some noteworthy steps have also been taken in the European legal framework. In 2023 an attempt was made in France to pass a specific law criminalizing gynecological and obstetric violence — this time including also the *gynecological* element in the name. The French draft proposal is a pivotal starting point in Europe, for several reasons. In the explanatory memorandum accompanying the proposal, it recognizes gynecological and obstetric violence as a form of gender-based violence against women and acknowledges the imbalance of power in the relation between patient and medical staff, thus exacerbating the condition of vulnerability of the patients in those moments. It also provides a comprehensive picture of what constitutes gynecological and obstetric violence which is not limited to mere *physical* conducts, but also includes slurs, name-calling and verbal abuse.[8] Furthermore,

6 On the issue of gynecological and obstetric violence and attempts to define it, see: Pickles 2022; Quattrocchi 2019; Larrea et al. 2021; Sadler et al. 2016; Ferrão et al. 2022; Chadwick 2023; Brennan 2019.
7 Ley No. 19580, Ley De Violencia Hacia Las Mujeres Basada En Genero. Modificacion A Disposiciones Del Codigo Civil Y Codigo Penal. Derogacion De Los Arts. 24 A 29 De La Ley 17.514, 9 January 2018.
8 Proposition de loi n° 982 (2023).

the proposed definition of the crime of gynecological and obstetric violence highlights how it infringes upon human dignity, by creating a hostile and intimidatory condition for the patient, who is consequently put in a position to act contrary to their will, i.e. without voluntary given consent.

While the French attempt still remains a draft proposal, in 2025 Portugal adopted Law No. 33/2025, "Law to promote the right during pregnancy and childbirth."[9] The law introduces obligations for the government to raise awareness concerning obstetric violence in the context of sexual education, in order to promote respect for "sexual and reproductive autonomy and the elimination of gender-based violence" (Article 3) thus underlying the gendered nature of the phenomenon, as well as an obligation to provide specific training on the matter. Law No. 33/2025 also provides a definition, though it refers to *obstetric* violence only. Obstetric violence is defined as a both physical and verbal, exercised by health professionals on the body and reproductive parts of women. Unlike other existing definitions, the law clearly states that obstetric violence is carried out on women and "on other pregnant individuals" (Article2). The definition also stresses that obstetric violence amounts to inhuman treatment, however it does not include references to consent, which are present in the French proposal.

The Spanish region of Catalonia also offers a noteworthy example in this regard. Law no. 17/2020,[10] adopted by the Autonomous Community of Catalonia on the eradication of sexist violence, includes obstetric violence as well as other forms of violence towards the sexual and reproductive rights of women. The focus of the definition — again referring only to obstetric violence — is the inability to take conscious, autonomous and informed decisions about one's sexual and reproductive processes and choices. The definition also lists various conducts amounting to obstetric violence.[11] This definition encompasses many innovative elements, such as widening the practice to assisted reproduction and focusing on autonomy. Moreover, according to Article 4, paragraph 2), letter d), it extends obstetric violence to gynecological and obstetrical practices which do not respect "the decisions, the body, the health and emotional processes of women."

Despite these few — yet noteworthy — attempts, the international, regional and national frameworks concerning gynecological and obstetric violence offer

9 Lei no. 33/2025 de 31 de março, promove os direitos na gravidez e no parto e alter a Lei no. 15/2014 de 21 de março, 31 March 2025.

10 Ley 17/2020, de 22 de diciembre, de modificación de la Ley 5/2008, del derecho de las mujeres a erradicar la violencia machista, 22 December 2020.

11 Such as: forced sterilizations and abortions, but also forced pregnancies; preventing access to abortion or to methods for preventing sexually transmitted diseases and HIV, as well as to assisted reproduction methods.

a scattered and fragmented scenario. However, identifying and agreeing upon a definition, especially from a legal perspective, is certainly a crucial step in addressing this phenomenon. Aside from ensuring that all forms of gynecological and obstetric violence are tackled — thus not only the physical, but also the verbal and psychological abuse — a comprehensive definition should take into account the element of free and informed consent (or better, the lack of it) which is a core issue in the context of violations of sexual and reproductive rights of women.

3 Framing gynecological and obstetric violence as a violation of human rights

Gynecological and obstetric violence is a multi-layered phenomenon, which can include physical, psychological and verbal abuse and mistreatment. It is comprised of several practices (Šimonović 2019),[12] some of which, if performed with the patient's consent, do not necessarily lead to gynecological and obstetric violence. For instance, an abortion, a C-section, or even a sterilization procedure (to name a few), if carried out with the voluntary, informed and unconditioned consent of the patient, are normally administered procedures within hospitals and healthcare facilities. The European Court of Human Rights (ECtHR) stated in *V.C. v. Slovakia* and in *N.B. v. Slovakia* that the forced sterilization of the two applicants following the delivery of their children (even though they had been led to signing some documents to undergo the procedure — in a language they did not speak fluently, without the support from a translator, and heavily drugged to mend the pain) amounted to substantive violations of their rights under Articles 3 (freedom from inhuman or degrading treatment) and 8 (right to private and family life) of the European Convention of Human Rights (ECHR).

The violation of the right to private and family life, as well as the violation of the right to be free from inhuman or degrading treatment, are only two examples of human rights violations gynecological and obstetric violence can amount to. The following pages will focus on how human rights courts and treaty bodies have dealt

12 In her report the Special Rapporteur enumerates a number of practices which can amount to gynaecological and obstetric violence, such as symphysiotomy; episiotomy; forced sterilizations and forced abortions; being tied or cuffed to a hospital bed during childbirth or abortion; unnecessary caesarean sections or deliveries; overuse of oxytocin to induce contractions; exposing patients to unexperienced medical staff during labour; manual fundal pressure to facilitate childbirth; sharing patients' health information without regard for privacy or consent; profound humiliations; verbal abuse and sexist remarks.

with some cases of gynecological and obstetric violence, highlighting the human rights violations found.

In the cases brought to the ECtHR, though the Court never specifically addressed the issues as gynecological and obstetric violence, the violations concerned the prohibition of torture and inhuman or degrading treatment and to the right to private and family life. Gynecological and obstetric violence infringes upon the dignity of women, protected under Article 3 ECHR, and renders them unable to perform decisions concerning their own body and reproductive health, amounting to violations of Article 8 (Dal Monico 2024, cf. also Dal Monico forthcoming). However, what the Court did not identify in that context was a violation of Article 14 ECHR, dealing with non-discrimination — even though the two patients, young women of Roma ethnic origin, were subjected to those procedures due to a bias towards people of Roma origin. Indeed, in her dissenting opinion judge Mijović firmly disagreed with the Court's decision not to engage in a broader reasoning on Article 14, which reduced the case to an individual dimension, not addressing the systematic discrimination of Roma women in Slovakian hospitals.[13] Though the Court did not find the actions of the medical staff in both *N.B.* and *V.C.* as deliberately aimed at ill-treating the patients, the non-consensual nature of the acts, as well as the physical and psychological damages caused to them, were perceived as being severe enough to meet the threshold for inhuman treatment.[14]

Cases of gynecological and obstetric violence amounting to inhuman or degrading treatment were decided also by the InterAmerican Court of Human Rights (IACtHR), which has adopted a more extensive approach in its appraisal of gynecological and obstetric violence-related cases, compared to its European counterpart. In the 2016 case *I.V. v. Bolivia*, it dealt with forced sterilization. I.V. was a young woman of Peruvian nationality, who obtained the refugee status together with her partner and daughters in Bolivia after fleeing from Peru. In 2000, being pregnant with her third child, she was admitted to the Women's Hospital in La Paz after experiencing the spontaneous rupture of the membranes, in her 38th week of pregnancy. Since her child was in a transversal position and she had not entered into labour at that point, the medical staff decided to perform a C-section. During the procedure, after her third child was born, the medical staff performed a tubal ligation to which she had not given consent. The medical staff had her husband sign a form, prior to the surgery, to authorize the C-section. The form was not signed by I.V. So, even

13 Dissenting opinion of Judge Mijovic in the case of V.C. v. Slovakia, No. 18968/07, ECtHR (Former Fourth Section), 8 November 2011.

14 For a feminist critique of Article 3 ECHR with specific reference to the cases of gynaecological and obstetric violence, see Dal Monico forthcoming.

if she was conscious as she underwent the operation under epidural anesthetic, they went looking for her husband during the procedure to have him authorize the sterilization, but they could not find him. In her file, the doctors wrote that she had given verbal consent to the sterilization while in surgery, but, in front of the domestic Courts, she firmly denied having ever agreed to it, as she only learned what had been done to her a few days later.

Eventually, the Court stated that Bolivia had violated Articles 5.1 (right to humane treatment) in particular in regards to the non-consensual nature of the sterilization; 7.1 (right to personal liberty); 11.1 (right to privacy); 13.1. (right to freedom of thought and expression) of the American Convention, as well as Article 7(a) of the Belém Do Pará Convention, which enshrines the right for women to be free from violence. The Court's evaluation demonstrates the impact that gynecological and obstetric violence practices can have on human rights, as well as the necessity to assess such cases with an intersectional approach and bearing in mind the gender-based nature of the phenomenon. Indeed, the Court noted how multiple factors of discrimination converged intersectionally in this case, also with regard to access to justice, highlighting how the patient's gender, socio-economic condition and refugee status were key factors in the discrimination she suffered (Dal Monico 2024).

The IACtHR addressed the issue of gynecological and obstetric violence, with a (tentative) intersectional approach, also in *Manuela et al. v. El Salvador*, by recognizing how the applicant's socio-economic and cultural background exacerbated her condition of vulnerability, whereby she was discriminated against by the hospital staff, who verbally abused and degraded her. Manuela was subjected to different practices amounting to gynecological and obstetric violence: she was shackled to her bed without necessity, she had her medical information disclosed without consent, and she was verbally abused by the staff who believed she had induced the abortion herself.[15]

The contribution of human rights treaty bodies and human rights courts is of paramount importance in framing how gynecological and obstetric violence impacts other human rights. In the absence of a specific legally binding definition or of the establishment of a right to be free from gynecological and obstetric violence in human rights law, such efforts in drawing the boundaries and establishing the content of such violations are a crucial means towards the eradication of the

15 The young woman was admitted to the hospital in severe pain as a consequence of a natural abortion, but she was suspected of having procured it herself, which is illegal in El Salvador. For this reason, she was reported to the police by the medical staff and arrested. While under arrest, she was shackled to her bed, though her condition was so critical — Manuela was also suffering from an undiagnosed Non-Hodgkin lymphoma — that prevented her from moving at all.

phenomenon. The specific contribution of the CEDAW Committee in this regard was also crucial in establishing two features at the basis of gynecological and obstetric violence: that it is a form of gender-based violence against women and that it amounts to a violation of women's human rights (among others, their right to reproductive health) (Bernardini and Dal Monico 2024). Furthermore, the CEDAW Committee's assessment of gynecological and obstetric violence has also proved instrumental in establishing that the practice entails forms of gender stereotyping.

In *S.F.M. v. Spain*, the CEDAW Committee found a violation of the applicant's rights under Articles 2(b)(c)(d) and (f), 3, 5 and 12 of the CEDAW Convention.[16] The applicant claimed that she had to undergo certain procedures to which she had not consented, such as early induced labour through oxytocin, forced lithotomy position during childbirth and an episiotomy alongside repeated (unnecessary) digital vaginal exams (a total of 10 in less than 48 hours, leading to her daughter contracting E. coli bacteria upon delivery and being taken away to undergo treatment right after birth — resulting in a week long separation from her mother). Moreover, the stereotypes that were at the basis of the mistreatment she suffered at the hospital were also prolonged during administrative and judicial proceedings, violating her right to be free from discrimination. The Committee stated that:

> the author maintains that she received the poor care that is the subject of the present complaint precisely because of the persistent gender stereotypes related to motherhood and childbirth: first the health personnel and then the judges took the view that women should follow doctors' orders because they are incapable of making their own decisions (CEDAW 2020a, 8).

Furthermore, the domestic judges' appraisal of the author's account of the events, discrediting her suffering as a mere "matter of perception" revealed "a gender-stereotyped depiction of women as hysterical, mad and prone to exaggeration and whining."

In *N.A.E. v. Spain*, the Committee acknowledged the same breach of the applicant's fundamental rights enshrined in the CEDAW Convention. In this case, the applicant claimed also to have been induced into early labour through oxytocin, to have undergone ten digital vaginal examinations; to have undergone a caesarean section without her consent; being strapped down and prevented from holding her

16 Specifically, Article 2 establishes State parties' obligations to: (b) eliminate discrimination against women by adopting appropriate legislative measures; (c) establish legal protection on an equal basis with the rights of men; (d) refrain from engaging in any act or practice of discrimination. Article 3 concerns the obligation to adopt measures to ensure the advancement of women in the economic, social, and cultural fields on the basis of equality with men. Article 5 concerns gender stereotyping and prejudices, imposing the obligation to eradicate such patterns, while Article 12, as mentioned, concerns obligations in relation to the right to health.

newborn child, denied food and clarifications concerning what was being done to her. She also reported several incidents where, instead of meeting her requests for explanations, she was faced with demeaning and infantilizing comments such as: "calm down little girl" (CEDAW 2022, 3).[17] In the Committee's views, Spain had violated its obligation to take all appropriate measures to modify or abolish laws and regulations as well as customs and practices resulting in forms of discrimination against women and considered that "stereotyping affects the right of women to be protected against gender-based violence, in this case obstetric violence" (CEDAW 2022, 17). It also recognized that the applicant's right to sexual and reproductive health was violated, including the access to safe and high quality maternity free from discrimination (Bernardini and Dal Monico 2024).

A third case was brought against Spain in 2023, *M.C.P.D. v. Spain*, where the applicant alleged being repeatedly denied medications to ease the pain for a hiatal hernia she was suffering from and forced to dilate in the lithotomy position against her wishes. Ultimately, she was forced to undergo a C-section without her consent and without actual medical necessity, as she reported having overheard the medical staff saying that all the delivery rooms were full, hence the choice of a C-section. In its decision, the Committee stressed how often in similar cases of gynecological and obstetric violence, caesarean deliveries are performed without actual medical necessity, but mostly due to economic or time related reasons.

4 Missed opportunities at the international and regional levels: how to approach gynecological and obstetric violence moving forward?

Some considerations can be drawn with regard to how human rights courts and the CEDAW Committee have dealt with cases of gynecological and obstetric violence. Again, it is worth stressing that, in the absence of a legally binding definition at the international or regional levels, the efforts of courts and treaty bodies are crucial in defining the contours of gynecological and obstetric violence in human rights law. However, these efforts show precisely how such a legal void may lead to differences in how gynecological and obstetric violence is approached by courts.

In the cases decided by the CEDAW Committee and by the IACtHR, the gender-based nature of gynecological and obstetric violence clearly emerges. In considering

17 The author was 25 years old at the time.

the cases brought against Spain, the Committee highlighted how the nature of the stereotyping that the applicants were subjected to affected their right to be protected from gender-based violence, in relation not only to gynecological and obstetric violence but also to accessing remedies, in order to seek justice for what they had suffered. For instance, in *M.D.P.C v. Spain*, the Committee highlighted that:

> the administrative and judicial authorities of the State party applied stereotypical and therefore discriminatory notions of gender, for example, by assuming that it is the doctor who decides whether or not to perform a caesarean section, without exploring alternatives, explaining the reasons to the patient or seeking her informed consent, even though the author had expressed her opposition to the procedure (CEDAW 2020b, 16).

Another relevant aspect shared by the reasoning of both of the IACtHR and the CEDAW Committee lies in the recognition of the violation of the applicants' right to health. At the international level, the right to health is enshrined in Article 12 of CEDAW and in all three cases concerning Spain, the Committee identified a violation of the right to health.[18] In the Interamerican context, the right to health is not expressly enshrined within the Convention, yet the case law of the IACtHR has included health within the scope of Article 26 of the American Convention (ACHR), which concerns progressive development and obliges State Parties to adopt measures "with a view to achieve progressively [...] the full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter of the Organization of American States." In *Manuela et al.*, the IACtHR established a violation of Article 26 ACHR by El Salvador, hence a violation of the right to health, stating: "The right to sexual and reproductive health forms part of the right to health."[19] The ECtHR came to similar conclusions with regard to the violation of the applicants' right to reproductive health in both *V.C.* and *N.B.*, identifying a violation of Article 8 ECHR. The ECHR does not include a provision specifically aimed at the protection of the right to health, and has expanded the parameters of Article 8, concerning the right to private and family life, to include health-related matters and particularly cases concerning reproductive rights.[20] Yet, the ECtHR failed to recognize the gendered nature of this form of violation (Alaattinoğlu 2023) by not considering the discrimination suffered by the applicants.

Contrary to the CEDAW Committee and the IACtHR's approaches to gynecological and obstetric violence, which also indicate an intersectional appreciation of how

18 See CEDAW 2020a, para. 7.6; CEDAW 2022, para. 15.9; CEDAW 2020b, para. 7.14.

19 IACtHR 2021, 55. On the human right to health in the Interamerican system see Tripo 2023. Specifically on women's right to health, see De Vido 2021.

20 See also ECHR 2023.

different factors converge to exacerbate conditions of vulnerability and lead to further discriminations, the gender-based nature of gynecological and obstetric violence has not been so expressly acknowledged by the ECtHR, which did not recognize that the applicants' socio-economic and cultural backgrounds had played a significant role in what they experienced (Dal Monico 2024). Although the ECtHR did get to a conclusion similar to that of the IACtHR concerning forced sterilization, stating that it amounts to inhuman treatment, the overall approach of the Interamerican Court, which relied also on the Belém Do Pará Convention to interpret States' obligations in cases of gender-based violence against women, shows a more extensive appreciation of the phenomenon, which affects women because of their gender and because of a stereotyped perception of how a woman about to be a mother should act. Cook and Cusak (2010) stressed how pervasive false stereotypes in the health sector portray women as incapable of making rational decisions, which leads to disrespectful and patronizing attitudes as well as infantilization by the medical staff.

Recognizing how stereotypes are entrenched in gynecological and obstetric violence practices and its gender-based nature, which can lead to discrimination, would allow for a more comprehensive appraisal of the phenomenon and constitute a first step towards its eradication. As mentioned, gynecological and obstetric violence is an umbrella term which includes practices ranging from forced episiotomies and sterilizations to humiliating and debasing comments and verbal abuse, which share the element of being a form of gender-based discrimination and violence against women. The inclusion in the Istanbul Convention of forced sterilization and forced abortions, two practices which can amount to gynecological and obstetric violence, is a crucial step in the recognition of gender-based violence against women in the health sector. Moreover, the ECtHR could refer to the Istanbul Convention to interpret the ECHR law in cases of gender-based violence against women, including gynecological and obstetric violence (De Vido 2020).[21] Such a gender-sensitive approach would prove particularly relevant in cases of gynecological and obstetric violence. The practice often leads not only (and not necessarily) to physical damage, but also to psychological and emotional scarring and human rights violations which should be approached as forms of gender-based discrimination and violence.

21 The IACtHR, by applying the Belém Do Pará Convention, could interpret State obligations in cases of violence against women and conceptualize transformative reparations.

5 Conclusions

The lack of a legally binding definition of gynecological and obstetric violence at the international and regional levels leaves a legal void that regional courts of human rights and treaty bodies have to fill, resulting in fragmented approaches. In particular, there is a risk of not recognizing gynecological and obstetric violence as a gender-based phenomenon, which is deeply embedded in societal conceptions and stereotypes on how women should behave, what they should do and how they should act as mothers. Moreover, the deeply seeded notion in the health sector that the doctor-patient relation is heavily imbalanced in favor of the doctor, who is the "rational" one in the binomial, contributes to gynecological and obstetric violence. Further attempts at defining the practice from a legal perspective at the national, regional and international levels should then strive to recognize it as a gender-based discrimination that can amount to gender-based violence.

Future attempts should also focus on the notion of *consent*. Indeed, acts amounting to gynecological and obstetric violence share the underlying lack of the patient's informed and voluntary consent. Consent should be *voluntary*, meaning that no patient should be put in a position where they feel forced to accept certain practices, and it should come from the patient themselves — not from the husband, partner or a relative[22]; it should be *informed*, meaning that information should always be made available to the patient in a way that is accessible and understandable and the patient should be in a physical and mental state that allows them to understand what they are being told[23]; finally, the consent should be given prior to the performing of the acts. This would necessarily lead to redefining the doctor-patient relation as one based on consent and not on mere trust because "the doctor knows best" (Popowicz 2021), reshaping the imbalance of power and diverting from systemic prejudices (cf. also De Vido 2021).

22 See: *I.V. v. Bolivia.*

23 *Cf. V.C. v. Slovakia* and *N.B. v. Slovakia.* In both cases, the applicants did not understand the language and were not provided with a translator. Also, due to the pain they were suffering, the applicants were heavily medicated thus unable to give their valid consent.

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