Background Note•

Mistreatment and violence against women in reproductive health services with focus on childbirth: Human Rights based approach

Table of Contents

Introduction

Studies show that the mistreatment and violence against pregnant women[1] during facility-based[2] childbirth is occurring *across the globe*. A 2015 systematic review synthesized the existing global qualitative and quantitative evidence on the mistreatment of women during childbirth in health facilities and identified 65 studies containing research findings from 34 countries.[3] Human rights organizations have also published reports documenting the abuses women and girls experience during childbirth in health care facilities around the world.[4] However, "[d]espite the existing evidence that suggests women's experiences of disrespect and abuse during facility-based childbirth are widespread, its impact on women's health, well-being and choices as well as how to prevent it need further and careful examination.[5]

In 2014, noting that "a growing body of research on women's experiences during pregnancy, and particularly childbirth, paints a disturbing picture," the World Health Organization (WHO) issued a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth. In its Statement, endorsed by over 90 civil society and health professional organizations, the WHO listed some of the reported abuse including:

> "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."[6]

The Statement recognized the impact of this mistreatment and abuse on women, as well as children and families, underscoring that: "Such practices may have direct adverse consequences

for both the mother and infant."[7] The WHO called for "greater action, dialogue, research and advocacy on this important public health and human rights issue."[8]

In 2015, U.N. member states adopted the 2030 Agenda for Sustainable Development, which is designed to "leave no one behind" and as such is grounded in human rights principles. Through this Agenda, states committed to achieving the goals of healthy lives (Goal 3) and gender equality (Goal 5) by ensuring access to quality maternal health care and guaranteeing women's and girls' reproductive autonomy.[9] States also committed to "end all forms of discrimination against all women and girls everywhere" (Target 5.1) and "ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard" (Target 10.3).[10]

Building on these initiatives, the WHO and U.N. and regional human rights experts have continued to call attention to the mistreatment and violence against women during childbirth and pushed for states to take steps to ensure that women receive dignified, respectful health care during labor and childbirth. This "has now sparked new empirical research across different continents, an advocacy agenda and a growing number of interventions."[11] In 2018, for example, following research on what constitutes respectful maternal care during childbirth in health facilities, the WHO published global recommendations on intrapartum care for a positive childbirth experience.[12]

Human Rights Standards

In its most recent extension of the Special Rapporteur on violence against women's mandate, the Human Rights Council affirmed "that 'violence against women' means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and girls of any age, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life, and notes the economic and social harm caused by such violence."[13] The CEDAW Committee has subsequently further clarified in its 2017 General Recommendation on violence against women that:

> "Violations of women's sexual and reproductive health and rights, such as forced sterilization, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment."[14]

In fulfilling her mandate, the current Special Rapporteur on violence against women has issued multiple statements condemning the mistreatment and violence against women during facility-based childbirth.[15]

For example, in a statement on the implementation of the 2030 Agenda, the Special Rapporteur on violence against women, in concert with other human rights experts, called upon states to specifically "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."[16] Most recently, in a 2019 statement on Croatia, the Special Rapporteur and other U.N. human rights experts condemned the "pattern of abuse and violence against women undertaking medical procedures relating to their reproductive health," including during labor and childbirth, and made clear that a woman "must have her rights respected" in

childbirth. They called upon the Croatian government to take preventative measures and ensure accountability for the abuses experienced by women in health care facilities.[17]

International human rights bodies have played a vital role in setting standards and monitoring human rights violations in the context of maternal health, including childbirth. For example, in 2012, the Office of the High Commissioner for Human Rights (OHCHR) issued 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.[18] And, in 2011, the CEDAW Committee issued its decision in *Alyne da Silva Pimentel Teixeira v. Brazil*,[19] "the first decision of an international treaty body holding a government accountable for a preventable maternal death."[20]

Although human rights bodies have denounced many abusive practices as violations of human rights, their decisions and statements have often been siloed. They have looked at a specific set of abuses, such as forced sterilization and the shackling of incarcerated or detained women during childbirth, leaving many types of mistreatment "unaddressed or inadequately analysed under international human rights law."[21] In particular, they have not necessarily articulated the rights violations with the understanding that they form part of a range of abuses and mistreatment within the context of childbirth.[22]

A Continuum of Human Rights Violations

While the focus of this background note is on mistreatment and violence against women during facility-based childbirth, it is critical to contextualize these abuses as forming part of a wider set of discriminatory laws, policies, and practices faced by women and girls globally. More broadly, these abuses occur as part of a continuum of discrimination and violence against women seeking all forms of sexual and reproductive health care, including women seeking to terminate their pregnancies, undergo fertility treatments, obtain contraception, or in other sexual and reproductive health contexts.

For example, human rights bodies have recognized[23] that denying women access to abortion, whether in law or in practice, can rise to the level of torture or cruel, inhuman or degrading treatment.[24] The CEDAW Committee has further clarified that criminal laws that "compel[] women in cases of severe fetal impairment, including fatal fetal abnormality, and victims of rape or incest to carry pregnancies to full term, thereby subjecting them to severe physical and mental anguish, constitute[] gender-based violence against women."[25] Forcing women to carry these pregnancies to term and give birth illustrates the clear connection between other reproductive rights violations and that of mistreatment and violence against women during childbirth. Similarly, the U.N. ESCR Committee 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, "as it can lead to forced medical interventions or even forced pregnancies," and of her right to gender equality in her enjoyment of her right to health.[26]

The CEDAW Committee 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.[27] Human rights bodies have also consistently held that sexual and reproductive health information should not be misrepresented or withheld, and that pregnant women should be provided information on their health status and the health of their pregnancy.[28] Human rights bodies have further underscored that in order to fulfil

their obligations under the right to health states must adopt legal and policy measures to guarantee sexuality education in all educational institutions—and that sexuality education should be "unbiased, scientifically-accurate, evidence-based, age appropriate and comprehensive."[29]

This continuum of discrimination and abuse is often targeted against women and girls with intersectional identities; for example, as the Special Rapporteur on disabilities has noted, "girls and young women with disabilities are, almost without exception, prevented from making autonomous decisions with regard to their reproductive and sexual health, which can result in highly discriminatory and harmful practices," including forced sterilization, forced contraception, compulsory gynecological checks and forced abortion.[30]

The Forthcoming Report

In her forthcoming report, the Special Rapporteur aims to build on these standards to offer a more holistic presentation of the mistreatment and violence that women experience in facility-based childbirth, as well as its causes, and provide recommendations for states on how to address these issues. As such, the report seeks to lay the foundation for states to develop appropriate policies and strategies to ensure human rights-based care and accountability for human rights obligations and political commitments. The Special Rapporteur's report will be the first human rights analysis by a special procedure dedicated to the issue of mistreatment and violence experienced by women during facility-based childbirth.

This background note seeks to provide a foundation for understanding why this mistreatment and violence against women occurs, the types of mistreatment and violence that have been documented, and how the U.N. special procedures and treaty-monitoring bodies have addressed these practices in their work, to date. Although some forms of mistreatment and abuse discussed in this background note may be regarded as violence against women, it is important to recognize that many of these acts go well beyond acts, whether intentional or unintentional, that constitute forms of violence and extend to a range of human rights violations. Human rights bodies have found, for example, that these practices constitute violations of the rights to health, privacy, freedom from discrimination and freedom from inhuman and degrading treatment, among others.

Drivers of the Mistreatment and Violence against Women During Facility-Based Childbirth

The mistreatment and violence against women during childbirth is about denying women autonomy and agency. This effort to prevent women from exerting full control over their bodily autonomy and decision-making is reflected in both laws and practices.[31] At the national level, some states have failed to put in place a protective legal and policy framework to ensure women receive care that is respectful of their needs and desires and that prevents and addresses mistreatment during childbirth. This has slowly begun to change: for example, in recent years, some countries have passed laws or issued policies that expressly allow a woman to be accompanied by a companion of her choice during childbirth and developed broader legislation encouraging the "humanization" of childbirth.[32] However, other laws contribute to an environment of violence and mistreatment. These laws include spousal or third-party consent laws, and laws that deprive women with disabilities of their legal capacity, which replace women's decision-making with that of a family member or other institutional authority. They also encompass laws that recognize fetal personhood, prioritizing the life of the fetus over that of the pregnant woman.

Often, it is discriminatory practices within the health care field, which serve to deny women their reproductive autonomy in the context of childbirth. These practices include: verbal abuse; the

segregation and detention of women in maternity facilities on the basis of ethnicity or socioeconomic status; the withholding or denial of health-related information; and abuses of the doctrine of medical necessity. These practices are often justified in the name of tradition, culture and religion—grounds that human rights bodies have expressly stated may "not [be] used to justify violations of women's right to equality before the law and to equal enjoyment of all [] rights."[33]

Underpinning these laws and practices that seek to limit women's autonomy and agency are harmful gender stereotypes and forms of intersecting discrimination against women. The power imbalance often embedded in the provider-patient relationship further reinforces women's lack of reproductive autonomy. Health systems conditions and constraints also play a role in fueling the mistreatment of women during facility-based childbirth. These factors have been recognized by U.N. and regional human rights bodies to be drivers of the mistreatment and violence that women face when obtaining reproductive health care, including in the context of maternal health services.

Harmful Gender Stereotypes

Stereotypes about women's decision-making competence, women's natural role in society and motherhood fuel the laws and practices denying women's reproductive autonomy during childbirth. These stereotypes arise from strong religious, social and cultural beliefs and ideas about sexuality, pregnancy and motherhood.[34] The stereotype that women are overly emotional and vulnerable and are therefore incapable of making rational decisions about their medical care is particularly pervasive. In the reproductive health context, this stereotype is compounded by the stereotypes depicting women's primary role as mother, child bearer and caregiver.[35]

By ascribing "motherhood" as a woman's primary role, these gender stereotypes create the ideal of the "self-sacrificing mother."[36] While there is not robust analysis of gender stereotypes in the context of sexual and reproductive health care, there is a growing body of standards. The U.N. 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 self-sacrificing caregivers."[37] Similarly, the CEDAW Committee in *L.C. v. Peru*, affirmed that this stereotype "understands the exercise of a woman's reproductive capacity as a duty rather than a right."[38]

As such, any pain or suffering that accompanies the child bearing role is considered natural and expected, and health care providers may therefore not offer women the same pain management during labor and childbirth as they would offer to other patients in pain.[39] Similarly, the "self-sacrificing mother" is seen as willing to prioritize the purported best interests of the fetus and assume the risks of various interventions that may be harmful for her, such as caesarean sections, symphysiotomies (the surgical separation and widening of the pelvis to facilitate childbirth) or episiotomies (a surgical incision performed during childbirth to enlarge the vaginal opening and facilitate childbirth).

Notably, the Working Group on Discrimination against Women in Law and Practice has recognized that this "unnecessary medicalization … [has] functioned as [a] form of social control exercised by patriarchal establishments to preserve the gender roles of women."[40] The Working Group has specifically pointed to the overuse of caesarean sections in many countries as evidence of the overmedicalization of birth and suggests that "women are not given a free choice between different ways of giving birth."[41] The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has also noted the stereotypes specifically driving abuses during childbirth,

> "*In many States women seeking maternal health care face a high risk of ill-treatment, particularly immediately before and after childbirth. Abuses range from extended delays in the provision of medical care, such as stitching after delivery to the absence of anaesthesia. Such mistreatment is often motivated by stereotypes regarding women's childbearing roles and inflicts physical and psychological suffering that can amount to ill-treatment.*"[42]

Finally, these stereotypes interact such that health care providers in some cases do not seek women's informed consent, instead substituting their beliefs about the best course of treatment for those of the women. Such treatment is often justified on the basis of the purported interests of the fetus, or the best interest of the woman, but reinforces the stereotype that women are unable to make informed decisions and reduces them to objects of intervention without agency.[43]

Notably, even when courts and human rights bodies directly or indirectly address stereotypes driving laws and practices, most fail to address the intersectional discrimination or compounded stereotypes experienced by subgroups of persons, which impedes the ability of women, girls and other marginalized groups to access justice. For example, in the context of forced sterilization during childbirth, courts and human rights bodies have failed to adequately articulate that the practice is occurring against particular groups of women, such as Roma women or women living with HIV. In so doing, they have not recognized that fueling these practices are health care providers' stereotypes about women living with HIV, who are seen as unable to care for children, and about Roma women, who are depicted as promiscuous and "hyper-fertile."[44] This latter stereotype "play[s] into fears that [the Roma] threaten the majority status of the [white] population"[45] and, as the Special Rapporteur on minorities has recognized, leads to practices such as coerced sterilization and other "forms of gender-based violence."[46]

Intersectional Discrimination

All of these forms of mistreatment and violence against women constitute gender-based discrimination, which is often further compounded by other forms of discrimination faced by these women in the context of sexual and reproductive health, including childbirth. The Committee on Economic, Social and Cultural Rights has noted that "groups such as, but not limited to, poor women, persons with disabilities, migrants, indigenous or other ethnic minorities, adolescents, LGBTI persons, and people living with HIV/AIDS are more likely to experience multiple discrimination" in this context.[47] Other human rights bodies have additionally underscored race, cast and religion or belief as grounds upon which women experience multiple discrimination.[48] 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 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."[49] The study found that the odds of experiencing disrespect and abuse were 3.6 times higher among females with low socioeconomic status.[50]

Similarly, women and girls with disabilities may experience discrimination based on multiple aspects of their identity, including gender and disability.[51] This discrimination is based on harmful stereotypes about women and girls with disabilities. As the U.N. interagency statement on eliminating forced, coercive and otherwise involuntary sterilization explains: "Persons with disabilities are very often perceived as asexual or sexually inactive. However, they are sexual beings in the same way as other people, and may also wish to become parents and should not be deprived of their sexual and reproductive rights."[52] Nonetheless, "Women with intellectual

disabilities are often treated as if they have no control, or should have no control, over their sexual and reproductive choices; they may be forcibly sterilized or forced to terminate wanted pregnancies, based on the paternalistic justification that it is 'for their own good.'"[53] The Special Rapporteur on 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."[54]

Power Dynamics in the Provider-Patient Relationship

Power dynamics in the provider-patient relationship are another root cause of mistreatment and violence. In any provider-patient relationship, there is an imbalance of power. The provider has the power of authoritative medical knowledge and the social privilege of medical authority,[55] while the patient is largely dependent on the provider for information and care. The U.N. Special Rapporteur on the right to health has recognized this power dynamic, describing the right to autonomy over decision-making as a counterweight to "the imbalance of power, experience and trust inherently present in the doctor-patient relationship."[56] This imbalance can be especially acute in the context of facility-based childbirth, as women may experience a heightened sense of vulnerability during the process of labor, childbirth, and the immediate post-partum period. The power dynamics between provider and patient are also a product of their specific social context: institutional maternity care "tracks lines of social disadvantage," mirroring "the inequalities of the society in which it functions."[57]

This power imbalance is particularly apparent in providers' abuse of the doctrine of medical necessity to justify mistreatment and abuse during childbirth. The forced sterilization of women following childbirth is one such example, where providers have sought to justify performing the procedure without the woman's consent as somehow necessary for the best interests of the woman.[58] 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."[59] Although providers do not necessarily have the intent to ill-treat their patients, "medical authority can foster a culture of impunity, where human rights violations do not only go unremedied, but unnoticed."[60]

Health Systems Conditions and Constraints

Health systems need to be better able to prevent and effectively respond to mistreatment and violence against women, this includes for women who experience such treatment in the health system during childbirth or when accessing other sexual and reproductive health services as well as for those women who experience violence by intimate partners or other forms of violence.[61] In the context of maternal health care, health systems conditions and constraints play a role in driving the mistreatment and violence against women during childbirth. States have an obligation to ensure the availability and quality of maternal health care facilities, goods and services, and the adequate training of providers.[62] To fulfil this obligation, states "must devote the maximum available resources to sexual and reproductive health"[63] and adopt a human rights-based approach to identifying budgetary needs and allocations.[64] However, many states have failed to prioritize women's health care in their budgets.[65] Human rights bodies have recognized that a state's failure to dedicate adequate resources to women's specific health needs is a violation of women's right to be free from discrimination.[66] In addition, many states fail to ensure that health workers are adequately trained on medical ethics and patients' rights, including providers' obligations to provide respectful, non-discriminatory care.[67] Further, 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 behavior."[68]

In addition to resource limitations, labor conditions within health systems play a role in driving the mistreatment and violence against women during childbirth. Health workers have explained "how hierarchical authority in the health system legitimized the control health workers had over women during childbirth," and led providers to believe they could act in coercive or discriminatory ways.[69] The "entrenched gender-based discrimination within the largely female health workforce, as evidenced by physical and sexual violence, wage gaps, irregular salaries, lack of formal employment and in ability to participate in leadership and decision-making"[70] also plays a role in normalizing and thereby perpetuating mistreatment. A 2016 WHO global survey of midwives "reveal[ed] 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."[71] U.N. agencies have therefore urged states to pay "particular attention . . . to the gendered nature of the workforce" and ensure gender-sensitive facility-level policies and health professional regulations in order to address discrimination against women health workers in health care settings.[72] In discussing the structural dimensions of providers' mistreatment and violence against women during childbirth, one paper notes that: "The poor working conditions of many health professionals should also be framed as forms of disrespect and abuse."[73]

Finally, the lack of accountability and mechanisms for redress within many health care systems leaves "women feeling vulnerable and powerless to seek justice for their mistreatment."[74] This impunity empowers providers to continue to mistreat women and reinforces an institutional culture where this mistreatment and violence is condoned and may even be expected. As Freedman and Kruk explain, these abuses "represent[] a breakdown in accountability of the health system not only to its users but also to the women and men it employs as service providers. Themselves subject to degrading and disrespectful working conditions, providers' professional ideals often succumb to the pressure of emotional and physical survival strategies."[75]

The Types of Mistreatment and Violence against Women During Facility-Based Childbirth

The types of mistreatment and violence experienced by women during facility-based childbirth have been categorized as: physical abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health systems conditions and constraints, under the typology used by the WHO.[76] This mistreatment and violence is more likely to occur against women from, for example, minority racial and ethnic groups, women of lower socioeconomic status, migrants, women with disabilities, adolescents, women living with HIV, and unmarried women—women who experience intersectional discrimination on multiple grounds.

Typology of mistreatment during facility-based childbirth[77]		
1) Physical abuse [Pinched; kicked; slapped; punched; hit with an instrument; gagged; physically tied down; forceful downward pressure]	**2) Verbal Abuse** **[**Shouted; insulted; scolded; *mocked* women's physical appearance, baby's appearance, women's sexual activity; *threatened with* medical procedure, physical violence, poor outcome, withholding care; blamed]	**3) Stigma and Discrimination** [Economic circumstance; race; educational level; marital status; religion; HIV status]

4) Poor rapport between women and providers • Autonomy [Mobilization during labour; preference of birthing position] • Supportive care (birth companion) • Communication	• **Failure to meet professional standards** • Informed consent and confidentiality • Pain relief • Neglect, abandonment and long delays	**5) Health systems conditions and constraints** • Lack of resources • Facility culture

Physical and Sexual Abuse

Physical abuse during childbirth may entail beatings, hitting, slapping, kicking and pinching by nurses, midwives or doctors.[78] One woman from Ghana explained:

> "*When I was due for labour and was asked to push, I couldn't push and the nurse beat me very well. She used a cane to whip me so I could push, but I told her I was tired but she insisted I should push. So she really whipped me with the cane and later used her hand to hit my thigh. There I became conscious and was able to push*."[79]

Women also report being "physically restrained during labor with bed restraints and mouth gags."[80] In the U.S., pregnant women who are incarcerated in prisons and jails or held in detention because of their immigration status, are reported to be shackled and restrained "during labor, delivery and the post-delivery recovery period, for hours or even days, despite the fact that armed guards are with them at all times."[81]

Other forms of physical abuse include providers conducting painful and medically unnecessary vaginal exams during labor[82] and providers' deliberate refusals to give women pain medication or anesthesia during childbirth.[83] Women are also subjected to deliberate delays in the provision of care, such as stitching after childbirth,[84] and neglect by providers during labor and childbirth—sometimes to the point of death or severe disability.[85]

Women have also reported sexual abuse by health care providers during childbirth. One study, which focused on women's experience of mistreatment during childbirth in a hospital in Nigeria, found that 2.0% of women interviewed reported being sexually abused by a health worker.[86]

Verbal Abuse and Humiliation

Studies and human rights reports have documented abusive, rude or harsh language and judgmental or accusatory statements by health care providers towards women in labor. Women report being mocked, scolded, insulted and yelled at by providers.[87] For example, in Nigeria, one woman in labor was told by a midwife upon arrival at the hospital: "oya, go outside goat…Ehn see this goat, go outside, it's not yet time, it's not time, what are you doing here, you are disturbing me."[88] In Brazil, it has been reported that "one of the most common insults was "Na hora de fazer não chorou" ("You didn't cry like that when making the baby")."[89]

Women and girls who do not conform to social norms or that face intersectional discrimination, including racial and ethnic minorities, migrants, or women from a lower socioeconomic status,

are at heightened risk of verbal abuse. For example, unmarried adolescent girls face demeaning verbal abuse during childbirth because of their age and their marital status. As one adolescent from Ghana explains: "When you get pregnant and you go to the hospital [to give birth] they would insult you because you are a teenager."[90] Similarly, 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. Fear of such discrimination was considered a powerful disincentive to deliver in health facilities in Ghana, Sierra Leone, and Tanzania."[91]

A recent report on Slovakia found that medical personnel often made derogatory remarks towards Roma women about how frequently they had sexual intercourse and the number of children they had, based on the negative gender stereotype that Roma women are "promiscuous." A Roma woman from Slovakia was told by the maternity department staff when she arrived to give birth: "You're here again! You've come again to spread your legs!" And, after childbirth, when she requested additional sanitary pads for the bleeding, they told her: "You buy them yourself if you have money. You can fuck, you can give birth, so you can buy [sanitary pads]."[92]

Women have also reported experiencing threats to withhold treatment or of physical violence or poor outcomes by health care providers during childbirth. This verbal abuse included "threats of beatings if the woman was noncompliant . . . and blame for their baby's or their own poor health outcomes."[93]

Denial of Care, Segregation, Removal and Detention

Women experience discriminatory denials of care, segregation, involuntary separation from their newborns and detention in the context of facility-based maternity care. Discrimination in these contexts is aimed at women with intersectional identities, including ethnic minorities, women living with HIV, migrants and women of lower socioeconomic status. For example, women who present at a health care facility during labor may be refused care entirely, on grounds of economic or other discrimination, including HIV status. Women have also reported being refused pain medication during childbirth because of an inability to pay.[94] In some settings, women from marginalized groups, such as migrants and refugees, may be "expected to pay higher rates for services or to pay bribes" in order to receive care.[95]

Some maternity hospitals have adopted discriminatory practices of segregating women within the facility based on race, ethnicity or medical condition, such as HIV. For example, Roma women in Slovakia are placed in "Roma-only" rooms in maternity hospitals. These designated rooms are often over-crowded, with more beds than the "non-Roma" rooms; rather than use vacant beds in other rooms, the hospital may force Roma women to sleep two to a bed or place a Roma woman's bed in the hallway.[96] Women may also face the removal of their infants from their care against their will—and in the absence of a legitimate health-related justification. For example, the CEDAW Committee has expressed concern about the continued "unnecessary separation of newborns from their mothers without medical grounds" in the Czech Republic.[97]

The post-childbirth detention of women and their newborns in health care facilities because of their inability to pay the hospital fees is another example of mistreatment. This practice has been reported in a number of countries in Asia, Sub-Saharan Africa, Latin America and the Middle East.[98] In Kenya, detained women and their infants were 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.[99]

Violations of the Right to Informed Consent, the Abuse of the Doctrine of Medical Necessity and Denying Women's Choices

Violations of the right to informed consent occur in a number of contexts related to labor and childbirth, including forced sterilization immediately following childbirth, over-medicalized and unconsented to procedures during childbirth, and breaches of privacy during a woman's stay in the facility. Women are either not consulted at all and therefore never given the opportunity to make an informed choice, given insufficient information to make an informed decision, or their preferences are disregarded by health care providers in the provision of care.

Women from across the globe have reported being involuntary sterilized—without their knowledge or consent—by healthcare providers immediately following delivery or a Caesarean section.[100] In an abuse of the doctrine of medical necessity, providers will often justify this mistreatment as medically indicated because the woman would otherwise die from a future pregnancy. However, female sterilization is never an emergency procedure and the globally accepted standard of care is that women's informed consent must always be obtained prior to sterilization.[101]

Women have also been coerced into consenting to sterilization. In direct contravention of human rights law and health care providers' professional ethical obligations,[102] women living with HIV in Kenya have reported being asked to sign consent forms for sterilization while in labor and highly vulnerable; others have faced threats from providers to withhold baby formula or anti-retroviral medications if they refused to consent to sterilization. Many women also reported being deliberately misinformed about the nature of the procedure or been given insufficient information to make an informed decision about sterilization.[103]

Similarly, a study conducted in two hospitals in Mumbai, India, found that: "There was an informal code in both hospitals that women must accept tubal ligation after two deliveries and IUD insertion after the first. The typical strategies used to pressurise women were refusing discharge, threatening not to conduct the procedure or banning her from the hospital. Typically, consent for these predetermined choices was negotiated when women were at their most vulnerable."[104] The study quoted a health care provider at one of the hospitals as stating:

> *"What we prefer over here; what I have been doing here is; I am telling my juniors and have been told by my seniors; is that if the lady is in her active phase of labour, it is the best time to talk to her about TL [tubal ligation] … They are very receptive at that time and they are exclusively with me at that time inside the labour ward … They understand what pain it is, how it is good to not have it once again." (KSDE, Senior resident, MC, Female)*[105]

Symphysiotomies, another childbirth-related procedure once performed in some contexts without women's informed consent, were also justified on the basis of medical necessity. This was despite clear evidence of a less harmful alternative and the undeniable religious motivations underlying the use of the procedure, which was preferred by Catholic providers who did not want to limit the number of children a woman could subsequently have.[106] As the Committee against Torture has noted on this issue: "doctors declined to perform alternative procedures that would have caused substantially less pain and suffering for religious rather than medical reasons."[107]

Women have reported other coercive and unconsented procedures related to the over-medicalization of childbirth. For example, a recent report documenting the experience of women in Slovak health facilities stated:

> "Several women said some of the procedures during the birth had been carried out without their consent, for example, the administration of oxytocin and other medicines, episiotomy, breaking the waters, or fundal pressure applied by a member of the medical staff in order to speed up delivery. There were several procedures the medical personnel had used during the labour and delivery, of which the women learnt only afterwards. They were performed not only without women's consent, but even without their knowledge. In some cases, interventions were even performed against the will of these women. …"[108]

Providers have also acted without consent and respect for privacy and confidentiality when performing vaginal exams during labor, including in front of third parties;[109] permitting medical student observation of a woman during childbirth;[110] and sharing women's health information, such as HIV status, with third parties in the context of childbirth.

Women are also not given the information they need to make informed choices and exercise their personal autonomy. In some cases, providers have deliberately withheld, or denied women, information about their health or the health of the fetus.[111] However, studies have shown that often it's providers' poor or insufficient communication about the state of women's health and the nature of the proposed care during childbirth that creates serious obstacles to women's ability to make an informed choice. These communication challenges "sometimes stem from language or other interpretation barriers" but are also the product of providers' rushed "efforts to secure patient compliance."[112]

Women also report being unable to choose their preferred position for delivery during childbirth and instead are forced to labor lying down, on their backs. This denial of agency stems, in part, from the over-medicalization of childbirth: "some health workers explained that they had not been trained to deliver women in positions other than lying down and felt uncomfortable letting a woman choose her own birth position."[113] The issue of overregulation or denial of choice to give birth at home is also a growing concern.[114]

In a case pending before the Inter-American Commission on Human Rights, Eulogia, an indigenous Quechua-speaking woman from Peru, was physically forced from a squatting position onto a hospital bed in the midst of giving birth to her child. Despite her protests that the baby was about to be born and that she instead should be helped to give birth in the squatting position, her son, Sergio, was born as she was being forcibly hoisted by the nurse onto the bed. He "violently crash[ed] into the cement floor, hitting his head and cutting the umbilical cord" and knocking him unconscious.[115] Due to this traumatic brain injury at birth, Sergio suffered from severe disabilities for the rest of his life,[116] which ultimately led to his death, at age 10. This case illustrates the severe impact that these coercive practices can have, not only on women, but on children and families. It also illustrates the impact of intersectional discrimination on the provision of care during childbirth.[117] As Sen et al. note: "The care provided to indigenous people who are often at the lower ends of social and economic hierarchies tends to be non-evidence-based, risky and even harmful, including physical immobilisation, lack of privacy, multiple vaginal and cervical manipulations, routine episiotomy, and fundal pressure "[118]

These practices deter women from seeking and using maternal health care services and erode their trust in the health care system. They also have significant health impacts on women and their newborns. Routine abuse may also mean that "both health workers and patients may have come to expect and accept the poor treatment of women as the norm."[119] In addition to violating ethical principles for providers, these practices violate numerous human rights.

U.N. and Regional Human Rights Standards on the Mistreatment and Violence against Women During Facility-Based Childbirth

As noted earlier, international human rights bodies and experts have addressed some of the types of mistreatment and violence, described above. However, they have focused on a limited number of issues and their analysis of those issues has largely failed to take into account the broader context in which these abuses occur. As such, there is a lack of robust analysis of the range of abuses that women experience during childbirth, the context in which they occur, and the inherent discrimination of these practices, as well as the intersectional nature of the discrimination that many women face.

Nonetheless, treaty bodies and special procedures have articulated important standards relating to mistreatment and violence against women during facility-based childbirth. In particular, treaty bodies have affirmed that the right to health, including sexual and reproductive health, requires states to ensure the availability, accessibility, acceptability and quality of health facilities, goods and services,[120] including in the context of childbirth. In relation to mistreatment and violence against women during facility-based childbirth, human rights bodies have found violations of the rights to health, life, privacy, freedom from discrimination, freedom from inhuman and degrading treatment, and an effective remedy, among others.

U.N. Special Procedures

The Special Rapporteur on violence against women has issued a number of statements expressing concern about the mistreatment and violence against women during facility-based childbirth and calling for accountability. In addition to her joint statement on the implementation of the 2030 Agenda, where she called upon 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,"[121] the Special Rapporteur has issued statements regarding individual cases and country conditions.

In 2018, the Special Rapporteur issued a joint statement with the Follow-up Mechanism to the Belém do Pará Convention (MESECVI) Committee of Experts, the body charged with evaluating state parties' implementation of the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, on the Imelda Cortez case in El Salvador. Urging the El Salvadorian government to release Imelda Cortez, who was in prison pending a criminal trial because of an obstetric emergency, the statement noted:

> "These facts highlight the clear legal limitations existing in El Salvador in relation to the treatment of women with obstetric complications in their pregnancies, who have to face criminalization by the State, institutional and obstetric violence by the health services, and lack of access to justice in these cases. In addition, the postponement of the hearing and consequently, the prolongation of the pre-trial detention, aggravate the violation of Imelda's human rights to access justice."[122]

Further, in a 2019 statement on Croatia, the Special Rapporteur and other U.N. human rights experts expressed concern about "women being subjected to painful treatments without anaesthesia, including surgical miscarriage procedures, uterine scrapes, removal of placenta, stitching after birth, episiotomies being conducted against their will and disrespectful treatment of women by health personnel."[123] They called upon 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.[124]

Other special procedures have also addressed the mistreatment and violence against women during facility-based childbirth, including the U.N. Working Group on Discrimination against Women,[125] the U.N. Special Rapporteur on torture[126] and the U.N. Special Rapporteur on health.[127] In addition, the OHCHR has issued 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.[128]

U.N. Human Rights Treaty Bodies

The human rights treaty bodies have all addressed the issues discussed above in their general comments[129] and concluding observations.[130] For example, the CEDAW Committee, in its General Recommendation on women and health, has called upon states to ensure that women receive quality health services, "delivered in a way that ensures that a woman givers her full informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives."[131] The CEDAW Committee's General Recommendation on violence against women notes that: "Violations of women's sexual and reproductive health and rights, such as forced sterilizations, . . . abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment."[132]

Likewise, the CAT Committee has recognized in its General Comment on the implementation of article 2 of the Convention that: "The contexts in which females are at risk [of torture or ill-treatment and the consequences thereof] include . . . medical treatment, particularly involving reproductive decisions."[133] In its concluding observations, the CAT Committee has condemned the shackling of women during childbirth in the U.S.,[134] and the forced sterilization of women living with HIV and "practice of post-delivery detention of women unable to pay their medical bills" in Kenya.[135]

The Human Rights Committee has similarly issued concluding observations expressing concern about the forced sterilization of Roma in the Czech Republic and Slovakia[136] and failure to ensure accountability for the practice of symphysiotomies during childbirth in Ireland.[137] The CEDAW Committee, in its concluding observations on the Czech Republic, has expressed concern "about continued reports that childbirth conditions and obstetric services unduly curtail women's reproductive health choices, including: . . . Unnecessary separation of newborns from their mothers without medical grounds; . . . Frequent use of episiotomy without medical need and in contravention of the preference of the mother."[138]

The treaty bodies have also heard individual cases.[139] For example, in 2011, the CEDAW Committee issued a decision in the case of *Alyne v. Brazil*, which 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.[140] The CEDAW Committee found a violation of her right to health, among other rights, and recognized that Alyne "was discriminated against, not only on the basis of her sex, but also on the basis of her status as a woman of African descent and her socio-economic background."[141] The Committee called upon Brazil to provide reparations to Alyne's mother and daughter, provide adequate professional training for health workers on quality obstetric care, and hold health professionals accountable for violating women's reproductive rights.[142] It recognized that these violations reached system-level factors

of neglect, including the inadequate resources and ineffective implementation of state policies,[143] and underscored that the failure "to meet the specific, distinctive health needs and interests of women . . . constitutes . . . discrimination against women under . . . the Convention."[144]

Regional Human Rights Bodies

Regional human rights bodies have similarly 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. These include cases on forced sterilization during childbirth,[145] medical student observation of a woman in labor without informed consent,[146] the removal of a newborn from the mother's care without consent or a health-related justification,[147] and a medical intervention on a pregnant woman without her informed consent.[148]

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 Bolivia during a caesarean section. The Court further found that Bolivia had failed to uphold its obligation to prevent and investigate violence against women under the Convention of Belém do Pará.[149] A case concerning the forced sterilization of a woman living HIV in Chile[150] and a case on obstetric violence against an indigenous Quechua-speaking woman from Peru are currently pending before the Inter-American Commission on Human Rights. In addition, the Commission has issued a statement urging "States to document, investigate, and punish emerging forms of violence against women, girls, and adolescents, such as . . . obstetric violence."[151]

The African Commission on Human and Peoples' Rights has also addressed issues of mistreatment and violence against women during childbirth, issuing a Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services.[152] Further, the Special Rapporteurs on the Rights of Women and Human Rights Defenders of the African Commission on Human and Peoples' Rights, along with the Rapporteur on the Rights of Women of the Inter-American Commission on Human Rights and the U.N. Special Rapporteur on violence against women, were all co-signatories to the statement on the 2030 Agenda, which called upon states to "address acts of obstetric and institutional violence suffered by women in health care facilities."[153]

Actions Taken at the National Level to Address the Mistreatment and Violence against Women During Facility-Based Childbirth

Governments and civil society actors in some countries have begun to introduce initiatives to address the mistreatment and violence against women during childbirth, including training for health care providers on medical ethics and the provision of compassionate and respectful care. Litigation in domestic courts has resulted in decisions upholding women's right to respectful maternal health care and holding government and health care providers accountable for the mistreatment women experienced during childbirth. Some examples of actions and decisions that have been taken at the national level are listed below.

- In Ethiopia, the Ethiopian Medical Association, in collaboration with the Ministry of Health, has embarked on a year-long project to promote compassionate and respectful care among health professionals through training and public discussions. The project is a response to "inadequate pre-service training on medical ethics, increased number of

complaints of unethical behavior, declining public trust, the remedial and punitive nature of the current medical ethics governance systems and absence of system promotion that focus on prevention and social accountabilities." Training will focus on ethics and medico-legal issues and will be complemented by public discussions on the issues with health professionals, NGOs and other stakeholders.[154]

- In the United Kingdom, the National Health Services (NHS) England commissioned a review of maternity services in 2015, partly in response to an "investigation into the serious failings in maternity services" at a particular set of university hospitals and the subsequent desire for "the system as a whole" to benefit from the lessons learned.[155] The findings were published in 2016. *Better Birth: Improving outcomes of maternity services in England* included specific recommendations for various actors to improve the quality of maternal health services. These included: creating a "national standardised investigation process [for] when things go wrong"; developing indicators and benchmarks to improve the quality of maternity services; reforming the payment system for maternity services to address, among other things, " the challenges of providing sustainable services in certain remote and rural areas"; ensuring that women are "able to make decisions about the support they need during birth and where they would prefer to give birth"; and that women receive "unbiased information . . . to help them make their decisions and develop their care plan."[156]
- In Kenya, Tanzania, Sudan and South Africa, respectful maternity care included various interventions such as: "training in values and attitudes transformation; communication skills training; setting up quality improvement teams; disrespect and abuse monitoring; staff mentorship; improving privacy in wards (for example, with curtains or partitions between beds); improving staff conditions (for example, by providing tea for those on-shift); maternity open days; community workshops; mediation/alternative dispute resolution; counseling community members who have experienced disrespect and abuse; making provision for complaints; and educating women on their rights. One intervention was focused on companionship in labour, with an emphasis on empathic, respectful care, and one was focused on a communication-building package with staff."[157]
- In Peru, CARE spearheaded an effort to promote citizen participation in monitoring the health care system to ensure the delivery of quality maternal health care services.[158] "No Woman Left Behind" was "an initiative to strengthen local civil society groups' knowledge of and capacity to hold the state accountable for its human rights obligations through trainings on the right to safe pregnancy and childbirth and citizen surveillance of health services. As a result, civil society organizations undertook citizen monitoring of health services and were able to utilize these findings to advocate for improved services. Furthermore, this initiative enabled civil society organizations to engage with local and regional state actors charged with realizing the right to health."[159] The Peruvian Ministry of Health has adopted elements of this citizen monitoring program and used it to inform the development of national policies to promote public health care monitoring.[160]

- Uruguay, Argentina, Brazil and Puerto Rico have all passed laws granting women the right to be accompanied by a birth companion of their choice during labor and childbirth. Brazil and Argentina also developed broader legislation encouraging the "humanization" of childbirth.[161] Argentina's law "explicitly emphasises the rights of women, newborns, birth companions and families."[162]
- In some countries in Latin America, "women's groups and networks, feminists, professional organisations, 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.[163] This

new legal framework "specifically locates 'obstetric violence' at the nexus of gender-based violence and clinical malpractice, and interweaves elements of both respectful treatment and quality care."[164] A number of national-level initiatives have come out of the obstetric violence movement in Latin America, including:

  - Venezuela (2007), Argentina (2009), Suriname,[165] Panama (2013) and Mexico City (2014) have passed laws criminalizing obstetric violence.[166]
  - 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 Argentina and Venezuela's definitions [of obstetric violence] to include miscarriage and breastfeeding."[167]
  - In Chile, Spain, Argentina, Colombia and France, civil society groups have created Obstetric Violence Observatories. "In March 2016, they released a common statement declaring that obstetric violence has been one of the most invisible and naturalised forms of violence against women and that it constitutes a serious violation of human rights."[168]

- In Kenya, the High Court in Bungoma in *JOO v. The Attorney General and 4 others* (2018) found a violation of the petitioner's right to maternal health care, dignity, security, and freedom from cruel, inhuman and degrading treatment, rooting their decision in the Kenyan Constitution and in Kenya's international and regional human rights obligations. The Court ordered those responsible (the government official, hospital and three nurses) for the physical and verbal abuse and neglect she experienced during childbirth to make a formal apology to the petitioner for violating her rights.[169]
- In India, the New Delhi High Court in the case of *Laxmi Mandal & Others v. Deen Dayal Harinagar Hospital & Others* (2010), recognized a constitutionally and internationally protected right to maternal healthcare and ordered compensation for rights violations experienced by two women living in poverty and their babies during and related to childbirth. The court found that the cases concerned the protection and enforcement of the basic, fundamental right to life under the Constitution and the two inalienable rights that form part of the right to life: the right to health, in particular, reproductive health; and the right to food. These findings relied heavily on international human rights obligations of the state. [170]
- In terms of medical association ethical standards, the International Federation of Gynecology and Obstetrics (FIGO), a global organization of national professional societies of obstetricians and gynecologists, has developed guidelines on "Harmful Stereotyping of Women in Health Care" (2011), noting the nature and impact of harmful stereotyping in the provision of care to women and offering specific guidance for providers across the globe on how to avoid negative stereotyping in the provision of health care.[171]

Conclusion

Women have a right to dignified, respectful health care, free from discrimination, coercion and violence, throughout pregnancy and childbirth, as protected in international and regional human rights law and standards. The mistreatment and violence against women during facility-based childbirth is a serious violation of women's human rights. This mistreatment is a form of discrimination against women prohibited under international human rights standards. States have a due diligence obligation to prevent, investigate and punish human rights violations occurring

during childbirth, including those acts which constitute violence, whether by state or non-state actors.

To combat and prevent this mistreatment and violence against women, states should ensure effective laws and policies that address, and are applied to guarantee, human rights during childbirth. This includes legislative and policy measures to ensure informed choice is in line with internationally recognized health and human rights standards. States should also introduce regulatory measures that prevent further abuse. For example, Ministries of Health at the national level could adopt a version of the FIGO guidelines on "Harmful Stereotyping of Women in Health Care" (2011).[172]

States must ensure that health systems are better able to prevent and effectively respond to mistreatment and violence against women, this includes for women who experience such treatment in the health system during childbirth or when accessing other sexual and reproductive health services as well as for those women who experience violence by intimate partners or other forms of violence.[173] In the context of childbirth, health systems must have the resources they need to provide quality, accessible maternal health care, including through adopting a human rights-based approach to planning and budgetary processes[174] to ensure that women's health needs and interests are being met. Fulfilling this obligation requires ensuring that providers are trained to meet women's needs and guarantee respect for their human rights, both in and out of formal medical education.[175] As part of this effort, it is critical for states to engage in systematic monitoring of health care facilities to gain information about the conditions, accessibility and delivery of services. As the OHCHR has underscored, "Full respect for the rights of both health system users and health workers is fundamental to a rights-based approach."[176]

A human rights-based approach also requires establishing accountability mechanisms to ensure redress for victims of mistreatment and violence, including financial compensation, acknowledgement of wrongdoing and a formal apology, and guarantees of non-repetition. To ensure professional accountability, "effective standards should be in place to ensure quality of care, and sanctions by professional associations, medical councils and/or licensing bodies should be applied in the event of proven negligence, abuse or malpractice."[177] Institutional and health system accountability requires that complaint procedures be instituted in all health care facilities and maternal death reviews or audits "be conducted routinely in order that lessons may be learned at all levels of the health system" in order to "prevent future maternal deaths."[178]In all efforts at prevention, monitoring and redress, states and health care facilities must ensure that women are active and informed participants in accounting for their experiences and redesigning systems to ensure accountability.[179] These efforts must be inclusive of the voices of women who have experienced multiple, intersecting forms of discrimination.

Lastly, given that the mistreatment and violence against women and girls during facility-based childbirth violates the CAT, ICESCR, ICCPR, CEDAW, CRC, CRPD and CERD, as well as regional human rights instruments, international and regional monitoring mechanisms can play a key role in providing guidance to states on combatting and preventing such mistreatment in line with their international and regional human rights commitments. In addition, violence against women in childbirth violates regional human rights treaties that explicitly address gender-based violence, such as the Maputo Protocol, the Convention of Belém do Pará and the Istanbul Convention, giving regional monitoring mechanisms a particular responsibility in preventing this abuse and in ensuring accountability for rights violations. Human rights mechanisms and UN entities have a critical role to play in contributing to further research and discussions on violence and mistreatment during childbirth, and its impact on the human rights of pregnant persons and

others concerned, in order to develop human rights-based norms and standards and to prevent abuses and violations.

• This background note was prepared for the Special Rapporteur on Violence against Women by Christina Zampas at the University of Toronto, Faculty of Law, with the support of Alisha Bjerregard at Yale Law School. Guidance and reviews were provided by Lucinda O'Hanlon, Özge Tunçalp, Avni Amin and Hedieh Mehrtash at the World Health Organization.

[1] This background note refers to "women" and "girls" in discussing mistreatment and violence during facility-based childbirth. Although the majority of personal experiences with these abuses relate to cisgender women and girls—who were born female and identify as female, transgender men and people who identify as neither men nor women may have the reproductive capacity to become pregnant and so may be subject to mistreatment and violence in the context of childbirth. This research did not find studies that included individuals with these gender identities, and as a result this background note does not reflect any experience they may have had with facility-based childbirth.

[2] There is an increase in skilled birth attendance globally that requires efforts to improve both the coverage and quality of care provided to women at health facilities, including women's rights to dignified and respectful care. Mistreatment can occur at the level of interaction between the woman and provider, as well as through systemic failures at the health facility and health system levels. See Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018); World Health Organization, *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, WHO/RHR/14.23 (2015).

[3] 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 12(6) (2015) [hereinafter, "Bohren et al. (2015)"]. This work built on earlier work by researchers in this area. *See* Bowser D., Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth: report of a landscape analysis. Washington, D.C.: United States Agency for International Development (2010); Freedman LP, Kruk ME. Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. Lancet. 2014; 384:e42-4. *See also* Silal SP, Penn-Kekana L, Harris B, Birch S, McIntyre D. Exploring inequalities in access to and use of maternal health services in South Africa. BMC Health Serv Res. 2011 Dec 31;12:120–0; Small R, Yelland J, Lumley J, Brown S, Liamputtong P. Immigrant women's views about care during labor and birth: an Australian study of Vietnamese, Turkish, and Filipino women. Birth. 2002 Nov 30;29(4):266–77; and d'Oliveira AFPLA, Diniz SGS, Schraiber LBL. Violence against women in health-care institutions: an emerging problem. Lancet. 2002 May 10;359(9318):1681–5.

[4] See, for e.g., 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 the USA*. London: Amnesty International Secretariat (2010); Human Rights Watch, *"Stop making excuses": accountability for maternal health care in South Afric*a (2011); Citizen, Democracy and Accountability, *Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia* (2015); Center for Reproductive Rights, *Vakeras Zorales – Speaking Out: Roma Women's Experiences in Reproductive Health Care in Slovakia* (2017).

[5] World Health Organization, *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, WHO/RHR/14.23 (2015). See also Bowser D., Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth: report of a landscape analysis. Washington, D.C.: United States Agency for International Development (2010).

[6] World Health Organization, *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, WHO/RHR/14.23 (2015). There is a rather long history of the various terms used to explain this issue, which is well documented in a recent article by Gita Sen and others. These authors' explanation of the language they have proposed to use: "disrespect and abuse," provides useful guidance that encompasses the various drivers as well as the conduct needing to be addressed.

> "For our purposes of being both inclusive and incisive, we prefer the terminology of D&A

[disrespect and abuse] despite the above limitation for provider buy-in. In the context of obstetric care, we define disrespect as the violation of a woman's dignity as a person and as a human being on the basis of her economic status, gender, caste, race, ethnicity, marital status, disability, sexual orientation, or gender identity. Disrespect is often revealed in the biased normative judgements that health workers make about women and the resulting acts of omission or commission. Abuse refers to actions that increase the risk of harm to the woman and are not in the best interests of her health or well-being. Such actions may be learned and reproduced through the practices of institutional medicine. They may or may not be intended to cause harm and are often justified by resource constraints that can become a cover for prioritising the convenience of health providers over the well-being of the woman.

We identify three important advantages to this definition. It captures both intentional behaviours and unintended consequences. It is open to addressing institutionalised medical practices as well as socio-economic inequalities. And it allows us to identify both manifestations and underlying drivers of the problem.

This definition appears to meet the criteria spelled out by Vogel et al.: 'Any definition needs to adequately capture the health, human rights, legal and sociocultural dimensions of this problem. It should consider a range of possible acts (whether intentional or not), the risks (or potential risks) of harm or suffering to women, and that these events can occur in different levels of care.'" Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018), pgs. 7-8.

[7] World Health Organization, *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, WHO/RHR/14.23 (2015).

[8] World Health Organization, *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, WHO/RHR/14.23 (2015).The WHO has explicitly taken a human rights approach to framing this mistreatment, recognizing that women have the right to the highest attainable standard of health, including "the right to dignified, respectful health care throughout pregnancy and childbirth."

[9] Transforming our world: the 2030 Agenda for Sustainable Development, https://sustainabledevelopment.un.org/post2015/transformingourworld.

[10] Transforming our world: the 2030 Agenda for Sustainable Development, https://sustainabledevelopment.un.org/post2015/transformingourworld.

[11] Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018), p. 6, DOI: 10.1080/09688080.2018.1508173.

[12] World Health Organization, *WHO recommendations: intrapartum care for a positive childbirth experience* (2018). An evidence synthesis, published in 2017, reviewed existing qualitative data in an effort to determine what constitutes respectful maternal care during childbirth in health facilities. The findings of the synthesis supported the evidence base for the recommendations in the WHO's 2018 global guidelines on intrapartum care for a positive birth experience. Shakibazadeh et al., Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis (2017). 2017 also saw the publication of multiple studies seeking to understand the expectations and needs of women during childbirth in health facilities, in order to improve the quality of care delivered. *See, for e.g.,* Bohren et al., Defining quality of care during childbirth from the perspectives of Nigerian and Ugandan women: A qualitative study (2017); Kyaddondo et al., Expectations and needs of Ugandan women for improved quality of childbirth care in health facilities: A qualitative study; Ojelade et al., The communication and emotional support needs to improve women's experience of childbirth care in health facilities in Southwest Nigeria: A qualitative study (2017).

[13] Human Rights Council, *Resolution adopted by the Human Rights Council on 1 July 2016: 32.19. Accelerating efforts to eliminate violence against women: preventing and responding to violence against women and girls, including indigenous women and girls*, U.N. Doc. A/HRC/RES/32/19 (2016), para. 1.

[14] Committee on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, U.N. Doc. CEDAW/C/GC/35 (2017), para. 18.

[15] *See, for example,* OHCHR, *Croatia must act now to end violence and abuse against women in reproductive health procedures, say UN experts* (22 February 2019), https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=24198&LangID=E; OAS,

mesecvi, United Nations Human Rights Special Procedures, *Committee of Experts and the UN Special Rapporteur express their concern over the case of Imelda Cortez in El Salvador* (2018), https://www.ohchr.org/Documents/Issues/Women/SR/StatementMESECVI_EN.pdf.

[16] Joint Statement by UN Human Rights Experts, the Rapporteur on the Rights of Women of the Inter-American Commission on Human Rights and the Special Rapporteurs on the Rights of Women and Human Rights Defenders of the African Commission on Human and Peoples' Rights on "The 2030 Agenda for Sustainable Development and its implementation," http://www.achpr.org/news/2015/09/d192 [hereinafter, "Joint Statement by UN Human Rights Experts on the 2030 Agenda for Sustainable Development"].

[17] OHCHR, *Croatia must act now to end violence and abuse against women in reproductive health procedures, say UN experts* (22 February 2019).

[18] 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*, U.N. Doc. A/HRC/21/22 (2012), https://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf.

[19] CEDAW Committee, Alyne da Silva Pimentel v. Brazil: Commc'n No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011) [hereinafter, "CEDAW Committee, *Alyne v. Brazil* (2011)"].

[20] Rebecca J. Cook, Human Rights and Maternal Health: Exploring the Effectiveness of the Alyne Decision, Global Health and the Law, Journal of Law, Medicine and Ethics 103 (Spring 2013).

[21] Khosla and Zampas, et al., *International Human Rights and the Mistreatment of Women during Childbirth*, Health and Human Rights Journal, 18(2): 131–143 (2016).

[22] Khosla and Zampas, et al., *International Human Rights and the Mistreatment of Women during Childbirth*, Health and Human Rights Journal, 18(2): 131–143 (2016).

[23] For more on the human rights standards described throughout this paragraph, see OHCHR, *Information series on sexual and reproductive health and rights* (2015), available at https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx.

[24] See, for e.g., Human Rights Committee, *Mellet v. Ireland*, Communication No. 2324/2013, U.N. Doc. CCPR/C/116/D/2324/2013 (2016); Human Rights Committee, *Whelan v. Ireland*, Communication No. 2425/2014, U.N. Doc. CCPR/C/119/D/2425/2014 (2017); Human Rights Committee, *K.L. v. Peru*, Communication No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); 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: Report of the Committee*, U.N. Doc. CEDAW/C/OP.8/GBR/1 (2018) (on the limited access to abortion in Northern Ireland).

[25] 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: Report of the Committee*, U.N. Doc. CEDAW/C/OP.8/GBR/1 (2018), para. 83(a).

[26] Committee on Economic, Social and Cultural Rights, *S.C. and G.P. v. Italy*, Communication No. 22/2017, U.N. Doc. E/C.12/65/D/22/2017 (2019), paras. 10.3, 11.2.

[27] 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).

[28] U.N. Committee on Economic Social, and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, U.N. Doc. E/C.12/GC/22 (2016); *RR v. Poland*, No. 27617/04 Eur. Ct. H.R. (2011)

[29] U.N. Committee on Economic Social, and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, U.N. Doc. E/C.12/GC/22 (2016), para. 63, 28; CRC General Comment No. 15: The right of the child to the highest attainable standard of health (art. 24), Chapter IV, Section E, 2013, paras. 60, 69.

[30] *Report of the Special Rapporteur on the rights of persons with disabilities: Sexual and reproductive health and rights of girls and young women with disabilities*, U.N. Doc. A/71/133 (2017), paras. 8, 29-31.

[31] Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018) DOI: 10.1080/09688080.2018.1508173.

[32] See section on *Actions Taken at the National Level to Address the Mistreatment and Abuse of Women During Facility-Based Childbirth*, below.

[33] U.N. Human Rights Committee, General Comment No. 28: Equality of Rights Between Men and Women (Article 3), U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), para. 5. *See also* Committee on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, U.N. Doc. CEDAW/C/GC/35 (2017), paras. 7, 31.
[34] Rebecca J. Cook and Simone Cusack, Gender Stereotyping: Transnational Legal Perspectives (Philadelphia: University of Pennsylvania Press, 2010), p. 34.
[35] OHCHR, *Background paper on the role of the judiciary in addressing the harmful gender stereotypes related to sexual and reproductive health and rights: A review of the case law* (2018), p.3, 5-6.
[36] OHCHR, *Background paper on the role of the judiciary in addressing the harmful gender stereotypes related to sexual and reproductive health and rights: A review of the case law* (2018), p.3, 5-6.
[37] Human Rights Committee, *Mellet v. Ireland*, Communication No. 2324/2013, U.N. Doc. CCPR/C/116/D/2324/2013 (2016), para. 3.19.
[38] Committee on the Elimination of Discrimination against Women, *L.C. v. Peru*, Communication No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (25 Nov. 2011), para. 7.7.
[39] Juan E. Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc. A/HRC/31/57 (5 January 2016), para. 47.
[40] Report of the U.N. Working Group on the issue of discrimination against women in law and in practice, U.N. Doc. A/HRC/32/44 (2016) para. 73.
[41] Report of the U.N. Working Group on the issue of discrimination against women in law and in practice, U.N. Doc. A/HRC/32/44 (2016), at para. 74.
[42] Juan E. Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc. A/HRC/31/57 (5 January 2016), para. 47.
[43] Liiri Oja & Alicia Ely Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" (2016) 32(1) *Columbia Journal of Gender and Law*, p. 77.
[44] *See, for e.g., Report of the UN Working Group on the issue of discrimination against women in law and in practice*, U.N. Doc. A/HRC/32/44 (2016), para. 57.
[45] Center for Reproductive Rights, *Body and soul: forced sterilization and other assaults on Roma reproductive freedom in Slovakia* (2003), p.57.
[46] Human Rights Council, *Report of the Special Rapporteur on minority issues, Rita Izsak: Comprehensive study of the human rights situation of Roma worldwide, with a particular focus on the phenomenon of anti-Gypsyism*, U.N. Doc. A/HRC/29/24 (2015), para. 27.
[47] U.N. Committee on Economic Social, and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, U.N. Doc. E/C.12/GC/22 (2016), para. 30. The U.N. Committee on Economic, Social and Cultural Rights has further recognized that people living in poverty may face, "pervasive discrimination, stigmatization and negative stereotyping which can lead to the refusal of, or unequal access to, the same quality of ... health care as others." U.N. Committee on Economic Social, and Cultural Rights, General Comment 20: Non-Discrimination In Economic, Social and Cultural Rights, U.N. Doc. E/C.12/GC/20 (2009), para. 35. *See also* CEDAW Committee, *Alyne v. Brazil* (2011), para. 7.7 ("recognizing that discrimination against women based on sex and gender is inextricably linked to other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, cast, and sexual orientation and gender identity."); Committee on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, U.N. Doc. CEDAW/C/GC/35 (2017), para. 12; U.N. Committee Against Torture, General Comment No. 2: Implementation of Article 2 by States Parties, U.N. Doc. CAT/C/GC/2 (2008), para. 22 ("Being female intersects with other identifying characteristics or status of the person such as race, nationality, religion, sexual orientation, age, immigrant status etc. to determine the ways that women and girls are subject to or at risk of torture or ill-treatment and the consequences thereof."); Joint Statement by UN Human Rights Experts on the 2030 Agenda for Sustainable Development ("Violence against women, harmful gender stereotypes and multiple and intersectional forms of discrimination based on sex and gender lead to the violation of women's sexual and reproductive health rights.").
[48] *Id.*
[49] Nawab T, Erum U, Amir A, Khalique N, Ansari MA, Chauhan A. Disrespect and abuse during facility-based childbirth and its sociodemographic determinants – A barrier to healthcare utilization in rural population. J Family Med Prim Care 2019;8:239-45. Similarly, Sen et al. have noted: "Across Latin

America and in India, systematic documentation of religious, ethnic and racial minority women's interactions with providers speak of the "triple burden" they face when seeking institutional childbirth." Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018), p. 10.

[50] Nawab T, Erum U, Amir A, Khalique N, Ansari MA, Chauhan A. Disrespect and abuse during facility-based childbirth and its sociodemographic determinants – A barrier to healthcare utilization in rural population. J Family Med Prim Care 2019;8:239-45. See also, Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018), p.10 (noting that poor women may be disproportionately subject to mistreatment and to particular forms of abuse, as compared to their wealthier counterparts.).

[51] *See, for e.g*., *Report of the Special Rapporteur on the rights of persons with disabilities: Sexual and reproductive health and rights of girls and young women with disabilities*, U.N. Doc. A/71/133 (2017), para. 21 ("Girls and young women with disabilities belonging to groups that have been historically disadvantaged or discriminated against, such as indigenous peoples, religious and ethnic minorities, poor or rural populations, migrants and refugees, and lesbian, gay, bisexual, transgender and intersex persons, experience multiple and intersectional forms of discrimination in the exercise of their sexual and reproductive health and rights. For example, indigenous girls and women with disabilities face a higher risk of experiencing early marriage, sexual violence and unwanted pregnancy.") *Id*. at paras. 7, 53.

[52] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* (2014), p. 5. *See also* Committee on the Rights of Persons with Disabilities, General Comment 3 (2016) on women and girls with disabilities, U.N. Doc. CRPD/C/GC/3 (2016), para. 38 ("Harmful stereotypes of women with disabilities include the belief that they are asexual, incapable, irrational, lacking control and/or hypersexual. Like all women, women with disabilities have the right to choose the number and spacing of their children, as well as the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.").

[53] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* (2014), p. 5.

[54] *Report of the Special Rapporteur on the rights of persons with disabilities: Sexual and reproductive health and rights of girls and young women with disabilities*, U.N. Doc. A/71/133 (2017), para. 31.

[55] Joanna Erdman, Commentary: Bioethics, Human Rights and Childbirth (2015) 17 HHR 43.

[56] Anand Grover, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc. A/64/272 (2009), para. 45.

[57] Joanna Erdman, Commentary: Bioethics, Human Rights and Childbirth (2015) 17 HHR 43.

[58] Juan Méndez, *Report of the UN Special Rapporteur on torture and other cruel, inhuman and degrading treatment,* UN Doc. A/HRC/22/53 (2013), para. 32.

[59] V.C. v. Slovakia, No. 18968/07, European Court of Human Rights, (2012).

[60] Joanna Erdman, Commentary: Bioethics, Human Rights and Childbirth (2015) 17 HHR 43.

[61] On health systems response to intimate partner violence and sexual violence, see guidance provided by WHO, *Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines* (2013); WHO, *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers* (2017).

[62] U.N. Committee on Economic Social, and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, U.N. Doc. E/C.12/GC/22 (2016); African Commission on Human and Peoples' Rights, General Comment No. 2, Rights of Women in Africa, (Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c)) para. 60, available at http://www.achpr.org/□iles/instruments/general-comments-rights- women/achpr_instr_general_comment2_rights_of_women_in_africa_eng.pdf; CEDAW Committee, *Alyne v. Brazil* (2011).

[63] 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*, U.N. Doc. A/HRC/21/22 (2012), para. 45. U.N. Committee on Economic Social, and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, U.N. Doc. E/C.12/GC/22 (2016), para. 33.

[64] 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*, U.N. Doc. A/HRC/21/22 (2012), pgs. 4-8.

[65]

[66] See, for e.g., CEDAW Committee, *Alyne v. Brazil* (2011), para. 7.6; Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Women and Health (Article 12) (1999).
[67] World Health Organization, *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, WHO/RHR/14.23 (2015) ("Greater action is needed to support changes in provider behavior, clinical environments and health systems to ensure tha tall women have access to respectful, competent and caring maternity health care services. This can include … ensuring high professional standards of clinical care."). See also Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018) at p. 12-13.
[68] Bohren et al. (2015) at p. 20. 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. Bohren et al. (2015) at p. 14.
[69] Bohren et al. (2015) at p. 20. See also, Madhiwalla et al., *Identifying disrespect and abuse in organisationl culture: a study of two hospitals in Mumbai, India*, Reprod Health Matters. 2018; 26(53): 36–47 ("A paternalistic belief in their entitlement, even responsibility, to adjudicate women's best interest made overtly coercive and violent actions justifiable and morally acceptable.").
[70] Joint United Nations Statement on Ending Discrimination in Health Care Settings (2017).
[71] World Health Organization, International Confederation of Midwives, White Ribbon Alliance, Joint News Release: *WHO and partners call for better working conditions for midwives* (Oct. 13, 2016), https://www.who.int/en/news-room/detail/13-10-2016-who-and-partners-call-for-better-working-conditions-for-midwives.
[72] Joint United Nations Statement on Ending Discrimination in Health Care Settings (2017). See also World Health Organization, *Midwives' Voices, Midwives' Realities: Findings from a global consultation on providing quality midwifery care* (2016).
[73] Sadler et al., *Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence*, Reproductive Health Matters (2016), p. 51.
[74] Bohren et al. (2015) at p. 13.
[75] Lynn P Freedman, Margaret E Kruk, *Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas*, The Lancet, Vol. 384 (2014).
[76] Bohren et al. (2015).
[77] Bohren et al. (2015).
[78] Bohren et al. (2015).; Joint Statement by UN Human Rights Experts on the 2030 Agenda for Sustainable Development; OHCHR, *Croatia must act now to end violence and abuse against women in reproductive health procedures, say UN experts* (22 February 2019); Madhiwalla et al., *Identifying disrespect and abuse in organisationl culture: a study of two hospitals in Mumbai, India*, Reprod Health Matters. 2018; 26(53): 36–47.
[79] Maya et al., *Women's perspectives of mistreatment during childbirth at health facilities in Ghana: findings from a qualitative study*, Reproductive Health Matters, 26:53, 70-87, p.76.
[80] Bohren et al. (2015).
[81] Center for Reproductive Rights, *Submission on Human Rights Abuses of US Incarcerated Pregnant Women* (2009) p. 1, https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CRR_Submission_on_Human_Rights_Abuses_of_US_Incarcerated_Pregnant_Women.pdf. *See also* Human Rights Watch, *Detained and Dismissed: Women's Struggles to Obtain Health Care in United States Immigration Detention* (2009).
[82] Bohren et al. (2015) at p.17.
[83] *Id. See also* OHCHR, *Croatia must act now to end violence and abuse against women in reproductive health procedures, say UN experts* (22 February 2019); Madhiwalla et al., *Identifying disrespect and abuse in organisationl culture: a study of two hospitals in Mumbai, India*, Reprod Health Matters. 2018; 26(53): 36–47 ("In general, staff did not perceive any responsibility to respond medically to women's expressions of pain." One health care provider noted: *"See, pain is a very subjective phenomenon; and also depends upon the sensitivity of the woman, her ability to tolerate pain. Probably women who are more pampered by their husbands will not be able to bear pain.").*
[84] Juan E. Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc. A/HRC/31/57 (5 January 2016), para. 47.

[85] Juan E. Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc. A/HRC/31/57 (5 January 2016), para. 47; *See also* CEDAW Committee, *Alyne v. Brazil* (2011).
[86] Sexual abuse was defined as any action that pressured or coerced the woman to do something sexually against her wishes. I.I. Okafor, O.U. Emmanuel, and N.O. Samuel, Disrespect and Abuse During Facility-Based Childbirth in a Low-Income Country, Int'l Journal of Gynecology & Obstetrics 128 (2) (2015) p. 110-113.
[87] Bohren et al. (2015) at pgs.16-17.
[88] Bohren et al., *Mistreatment of women during childbirth in Abuja, Nigeria: a qualitative study on perceptions and experiences of women and healthcare providers, Reproductive Health* (2017) 14:9, p. 8.
[89] Vanessa Barbara, Opinion: *Latin America Claims to Love Its Mothers. Why Does It Abuse Them?*, The New York Times (March 11, 2019), https://www.nytimes.com/2019/03/11/opinion/latin-america-obstetric-violence.html?action=click&module=Opinion&pgtype=Homepage.
[90] Maya et al., *Women's perspectives of mistreatment during childbirth at health facilities in Ghana: findings from a qualitative study*, Reproductive Health Matters, 26:53, 70-87, p.75. "The nurses are not patient with us they will be insulting us especially when you are not married you are treated badly. (FGD, Women 15-19 years, Koforidua)." *Id.* at p.78.
[91] Bohren et al. (2015) at p.15.
[92] Center for Reproductive Rights, *Vakeras Zorales – Speaking Out: Roma Women's Experiences in Reproductive Health Care in Slovakia* (2017), p.7.
[93] Bohren et al. (2015) at p.15.
[94] Bohren et al. (2015) at p. 17. In addition to deliberate refusals to provide pain relief, structural barriers can also be responsible for the failure to provide pain management. For example, pain medication is also not always available in certain health care settings, due to stock outs.
[95] Bohren et al. (2015) at p. 10.
[96] One Roma mother explained: "There were two of us sleeping in one bed...[If only they'd put us] in the room next door when there were vacancies, but they wouldn't." Center for Reproductive Rights, *Vakeras Zorales – Speaking Out: Roma Women's Experiences in Reproductive Health Care in Slovakia* (2017) p.13.
[97] CEDAW Committee, Concluding Observations: Czech Republic, U.N. Doc. CEDAW/C/CZE/CO/6 (2016), para. 30(a).
[98] 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; *AP Investigation: Hospital patients held hostage for cash*, AP News, (Oct. 25, 2018), https://apnews.com/4ee597e099be4dfaa899f85e652605b5; Bohren et al. (2015) at p.19.
[99] Center for Reproductive Rights, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities* (2007), pgs.56-58.
[100] In the past few decades, the forced sterilization of women has been documented in Bolivia, Brazil, Chile, China, the Czech Republic, the Dominican Republic, Hungary, Kenya, Mexico, Namibia, Slovakia, South Africa and Venezuela, among other countries. *See, for e.g.*, Open Society Foundations, *Against her Will: Forced and Coerced Sterilization of Women Worldwide* (2011) available at https://www.opensocietyfoundations.org/sites/default/files/against-her-will-20111003.pdf; Center for Reproductive Rights, *Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities* (2010), p.10; World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* (2014); African Gender and Media Initiative, *Robbed of Choice: Forced and Coerced Sterilization Experiences of Women Living with HIV in Kenya* (2012).
[101] International Federation of Gynecology and Obstetrics (FIGO) Committee for the Ethical Aspects of Human Reproductive and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (Oct. 2015) pgs. 147-150.
[102] *See, for e.g.*, International Federation of Gynecology and Obstetrics (FIGO) Committee for the Ethical Aspects of Human Reproductive and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (Oct. 2015) pg. 148, para. 8: ("Women's consent to sterilisation should not be made a condition of access to medical care – such as HIV/AIDS treatment, natural or cesarean delivery, or abortion – or of any benefit such as medical insurance, social assistance, employment, or release from an institution. In addition,

consent to sterilisation should not be requested when women may be vulnerable, such as when requesting termination of pregnancy, going into labor, or in the aftermath of delivery.").

[103] African Gender and Media Initiative, *Robbed of Choice: Forced and Coerced Sterilization Experiences of Women Living with HIV in Kenya* (2012).

[104] Madhiwalla et al., *Identifying disrespect and abuse in organisationl culture: a study of two hospitals in Mumbai, India*, Reprod Health Matters. 2018; 26(53): 36–47.

[105] Madhiwalla et al., *Identifying disrespect and abuse in organisationl culture: a study of two hospitals in Mumbai, India*, Reprod Health Matters. 2018; 26(53): 36–47.

[106] In Ireland, up until the 1980s, women were routinely subjected to symphysiotomies, a surgical procedure used during childbirth that "severs one of the main pelvic joints and unhinges the pelvis." Human Rights Committee, Concluding Observations: Ireland, UN Doc. CCPR/C/IRL/CO/4 (2014) para. 11. Symphysiotomies resulted in severe and lifelong pain and disability and were typically performed without women's knowledge or consent. Long after caesarean sections were considered a safer alternative to symphysiotomies, the practice persisted in Ireland.

[107] Committee against Torture, Concluding Observations: Ireland, U.N. Doc. CAT/C/IRL/CO/2 (2017) para. 29. *See also* Professor Irene Anne Jillson, Symphysiotomy in Ireland: A Qualitative Study (2012) p. 3, available at www.patientfocus.ie/site/images/uploads/SYMPHYSIOTOMY_IN_IRELAND_By_Irene_Jillson_PhD.pdf (Up until the 1980s, long after the rest of Europe and North America had turned to caesarean sections and discontinued the practice of symphysiotomy, its use continued in Ireland. Its use was, in part, "championed by some Irish doctors…[because] it facilitated future vaginal deliveries," enabling "women to have an unlimited number of children," as opposed to caesarean sections which were believed by some to limit the number of children a woman could subsequently have.) According to Survivors of Symphysiotomy Ireland, some symphysiotomies "were not performed in an emergency or out of medical necessity, but as a matter of policy, out of personal choice. Some obstetricians and gynaecologists disliked Caesarean section because it capped family size. In place came symphysiotomy, a more dangerous procedure that enabled women to have an unlimited number of children." See http://symphysiotomyireland.com/.

[108] Citizen, Democracy and Accountability, *Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia* (2015), p. 189. *See also*, Amnesty International, *She is not a criminal: the impact of Ireland's Abortion Law* (2015), p. 47. ("The Association for Improvements in the Maternity Services Ireland (AIMS Ireland) [an organization that advocates for women's human rights in the context of childbirth] has documented numerous cases of rights abuses in the provision of maternal health care that are a product of the Eighth Amendment [which protects a foetus' right to life on an equal footing with a woman's]. In a recent statement they noted: *"[T]he Eighth Amendment is repeatedly used in the context of maternity rights to deny women the right to bodily autonomy in terms of decision making in pregnancy, in labour, in birth and in the postpartum period. Women have reported being forced into caesarean births, forced into invasive procedures during labour, threatened with social services and in some cases threatened with the Gardaí [police] and mental health services for trying to assert their right to bodily autonomy."* Krysia Lynch, Co-Chair and Spokesperson for AIMS Ireland, characterized the situation as the "*quashing of choice from the minute you're pregnant*.""); Vanessa Barbara, Opinion: *Latin America Claims to Love Its Mothers. Why Does It Abuse Them?*, The New York Times (March 11, 2019) ("One example is episiotomy, a surgical cut in the vagina made during labor that has been proven ineffective and even harmful when performed routinely. Doctors still perform it in Brazil, with or without the women's consent. And when it's suturing time, they sometimes include an extra stitch to supposedly tighten the vagina to increase male pleasure — a 'husband stitch.' (Five years ago, in Rio de Janeiro, an obstetrician was caught on video asking a patient's husband, 'Do you want it small, medium or large?')"); Nawab T, Erum U, Amir A, Khalique N, Ansari MA, Chauhan A. Disrespect and abuse during facility-based childbirth and its sociodemographic determinants – A barrier to healthcare utilization in rural population. J Family Med Prim Care 2019;8:239-45 ("In this study, nonconsented care was the most common manifestation of DA (71.1%). A majority of the females reported receiving episiotomy without consent.")

[109] Bohren et al. (2015) at p.17. *See also* Camille Pickles, *When 'assault' is not enough: Unauthorised vaginal examinations during labour and the crime of battery* (2019), forthcoming, on file with author; See also *Y.F. v Turkey*, unauthorized exams outside child birth setting found to violate the ECHR, Application no. 24209/94 (2003)

[110] *Konovalova v Russia*, No. 37873/04, European Court of Human Rights (2014).

[111] See, for example, *RR v. Poland*, No. 27617/04 Eur. Ct. H.R. (2011); See generally, Council of Europe, Commissioner for Human Rights, *Women's Sexual and Reproductive Health and Rights in Europe*, Issue Paper, December 2017.
[112] Khosla and Zampas, et al., *International Human Rights and the Mistreatment of Women during Childbirth*, Health and Human Rights Journal, 18(2): 131–143 (2016); Bohren et al. (2015) at p.18.
[113] Bohren et al. (2015) at p.18.
[114] The issue of overregulation or denial of choice to give birth at home is also a growing concern. For example, in the 2010 case of *Ternovsky v. Hungary*, the European Court of Human Rights 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, *"[t]he lack of legal certainty and the threat to health professionals has limited the choices of the applicant considering home delivery*," amounting to a violation of her private life, *Case of Ternovszky v. Hungary*, Application no. 67545/09, Judgment of 14 March 2011 (European Court of Human Rights); In contrast, see 2016 decision from the Grand Chamber of the Court in the case of *Dubská and Krejzová v. the Czech Republic*, Applications nos. 28859/11 and 28473/12, Judgment of 15 November 2016) and *Pojatina v Croatia*, Application no, 18558/12, Judgment 4 October 2018.
[115] IACHR, Report No. 35/14, Petition 1334-09, Admissibility, Eulogia and her son Sergio, Peru, April 4, 2014, paras. 10-11.
[116] IACHR, Report No. 35/14, Petition 1334-09, Admissibility, Eulogia and her son Sergio, Peru, April 4, 2014, at para. 13.
[117] Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018).
[118] Sen et al. continue: "It is also often rife with cultural bias and insensitivity, making the experience of childbirth physically and emotionally traumatic by forcing indigenous women who are used to delivering in squatting or other positions to deliver lying down, not allowing companionship, or insisting on unauthorised discharge of the placenta, which can carry deep cultural and spiritual significance." Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018) at p. 11.
[119] Bohren et al. (2015) at p.14.
[120] U.N. Committee on Economic Social, and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, U.N. Doc. E/C.12/GC/22 (2016), paras. 11-21; U.N. Committee on Economic Social, and Cultural Rights, General Comment No. 14:The Right to the highest attainable standard of health, (2000), para 12; See also, CRC General Comment No. 15: The right of the child to the highest attainable standard of health (art. 24), Chapter IV, Section E, 2013; CRC General Comment No. 15 on adolescent health has applied these norms to adolescents.
[121] Joint Statement by UN Human Rights Experts on the 2030 Agenda for Sustainable Development.
[122] OAS, mesecvi, United Nations Human Rights Special Procedures, *Committee of Experts and the UN Special Rapporteur express their concern over the case of Imelda Cortez in El Salvador* (2018).
[123] OHCHR, *Croatia must act now to end violence and abuse against women in reproductive health procedures, say UN experts* (22 February 2019).
[124] *Id.* The previous Special Rapporteur on violence against women, in her 2013 report, had also touched on the mistreatment of women during childbirth, expressing concern about the shackling of pregnant women during labor and delivery, including in the U.S. *Report of the Special Rapporteur on violence against women, its causes and consequences: Pathways to, conditions and consequences of incarceration for women*, U.N. Doc. A/68/340 (2013), para. 57.
[125] *Report of the Working Group on the issue of discrimination against women in law and in practice*, U.N. Doc. A/HRC/32/44 (2016).
[126] Juan Méndez, *Report of the Special Rapporteur on torture and other cruel, inhuman and degrading treatment*, U.N. Doc. A/HRC/22/53 (2013); Juan E. Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, U.N. Doc. A/HRC/31/57 (2016).
[127] Anand Grover, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, U.N. Doc. A/64/272 (2009); Anand Grover, *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, U.N. Doc. A/66/254 (2011).

[128] 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*, U.N. Doc. A/HRC/21/22 (2012).
[129] *See, for e.g.*, Committee on the Elimination of Discrimination against Women, General Recommendation No. 19: Violence against Women, U.N. Doc. A/47/38. (1992); Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Women and Health (Article 12) (1999); Committee on the Elimination of Discrimination against Women, General Recommendation 30 on women in conflict prevention, conflict and post-conflict situations, U.N. Doc. CEDAW/C/GC/33 (2013); Committee on the Elimination of Discrimination against Women, General recommendation No. 33 on women's access to justice, U.N. Doc. CEDAW/C/GC/33 (2015); Committee on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, U.N. Doc. CEDAW/C/GC/35 (2017); U.N. Human Rights Committee, General Comment No. 28: Equality of Rights Between Men and Women (Article 3), U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000); U.N. Committee on Economic Social, and Cultural Rights, General Comment No. 14:The Right to the highest attainable standard of health, (2000); U.N. Committee on Economic Social, and Cultural Rights, General Comment 20: Non-Discrimination In Economic, Social and Cultural Rights, U.N. Doc. E/C.12/GC/20 (2009); U.N. Committee on Economic Social, and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, U.N. Doc. E/C.12/GC/22 (2016); Committee on the Rights of the Child, General Comment No. 15: The right of the child to the highest attainable standard of health (art. 24), Chapter IV, Section E (2013); U.N. Committee Against Torture, General Comment No. 2: Implementation of Article 2 by States Parties, U.N. Doc. CAT/C/GC/2 (2008); Committee on the Rights of Persons with Disabilities, General comment No. 1 (2014), Article 12: Equal recognition before the law, U.N. Doc. CRPD/C/GC/1 (2014); Committee on the Rights of Persons with Disabilities, General comment No. 3 (2016) on women and girls with disabilities, U.N. Doc. CRPD/C/GC/3 (2016).
[130] *See, for e.g.*, CEDAW Committee, Concluding Observations: Slovakia, U.N. Doc. CEDAW/C?SVK/CO/5-6 (2015); CEDAW Committee, Concluding Observations: Chile, U.N. Doc. CEDAW/C/CHL/CO/5-6 (2012); CAT Committee, Concluding Observations: Czech Republic, U.N. Doc. CAT/C/CZE/CO/405 (2012), along with other concluding observations referenced in this section.
[131] Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Women and Health (Article 12) (1999), para. 22.
[132] Committee on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, U.N. Doc. CEDAW/C/GC/35 (2017), para. 18.
[133] U.N. Committee Against Torture, General Comment No. 2: Implementation of Article 2 by States Parties, U.N. Doc. CAT/C/GC/2 (2008), para. 22.
[134] CAT Committee, Concluding Observations: United States, U.N. Doc. CAT/C/USA/CO/2 (2006), para. 33.
[135] CAT Committee, Concluding Observations: Kenya, U.N. Doc. CAT/C/KEN/CO/2 (2013), para. 27.
[136] Human Rights Committee, Concluding Observations: Czech Republic, U.N. Doc. CCPR/C/CZE/CO/2 (2007), para. 10; Human Rights Committee, Concluding Observations: Slovakia, U.N. Doc. CCPR/CO/78/SVK (2003), para. 12.
[137] Human Rights Committee, Concluding Observations: Ireland, U.N. Doc. CCPR/C/IRL/CO/4 (2014), para. 11.
[138] CEDAW Committee, Concluding Observations: Czech Republic, U.N. Doc. CEDAW/C/CZE/CO/6 (2016), para. 30.
[139] CEDAW Committee, *Alyne v. Brazil* (2011); Committee on the Elimination of Discrimination against Women, *A.S. v. Hungary*, Communication No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006); Committee on the Elimination of Discrimination against Women, *L.C. v. Peru*, Communication No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (25 Nov. 2011); Human Rights Committee, *K.L. v. Peru*, Communication No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).
[140] CEDAW Committee, *Alyne v. Brazil* (2011). The CEDAW Committee has also decided *A.S. v. Hungary* (finding A.S.'s rights to health, health-related information and determine the number and spacing of her children were violated when a doctor in a public hospital sterilized her without her informed consent following an emergency Caesarian section). Committee on the Elimination of Discrimination against Women, *A.S. v. Hungary*, Communication No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

[141] CEDAW Committee, *Alyne v. Brazil* (2011), para. 7.7.
[142] CEDAW Committee, *Alyne v. Brazil* (2011).
[143] CEDAW Committee, *Alyne v. Brazil* (2011), para. 7.6.
[144] *Id.*
[145] 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).
[146] *Konovalova v Russia*, No. 37873/04, European Court of Human Rights (2014).
[147] *Hanzelkovi v Czech Republic*, No. 43643/10, European Court of Human Rights (2015).
[148] *Csoma v Romania*, No. 8759/0, European Court of Human Rights (2013).
[149] *I.V. v. Bolivia*, Preliminary Objections, Merits, Reparations and Costs, Judgment, Inter-American Court of Human Rights (ser. C) No. 329 (Nov. 30, 2016).
[150] IACHR, Report No. 52/14, Petition 112-09. Admissibility. F.S. Chile. July 21, 2014.
[151] 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* (March 8, 2018), http://www.oas.org/en/iachr/media_center/PReleases/2018/044.asp.
[152] African Commission on Human and Peoples' Rights, *Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services* (2013), available at http://www.achpr.org/sessions/54th/resolutions/260/.
[153] Joint Statement by UN Human Rights Experts on the 2030 Agenda for Sustainable Development.
[154] Ethiopian News Agency (Addis Ababa), *Ethiopia: Medical Association Announces Project that Enhances Health Ethics*, AllAfrica.com (22 March 2019), https://allafrica.com/stories/201903260302.html.
[155] National Maternity Review, *Better Births: Improving outcomes of maternity services in England, A Five Year Forward View for maternity care* (2016), p. 31.
[156] National Maternity Review, *Better Births: Improving outcomes of maternity services in England, A Five Year Forward View for maternity care* (2016), Annex A, p. 101-111.
[157] Downe et al., *Effectiveness of respectful care policies for women using routine intrapartum services: a systematic review*, Reproductive Health (2018) 15:23.
[158] Ariel Frisancho Arroyo, National Coordinator of Social Rights' Programs - CARE Peru, *Citizen Monitoring to Promote the Right to Health Care and Accountability* (2013).

[159] Center for Reproductive Rights, *From Risk to Rights: Realizing States' Obligations to Prevent and Address Maternal Mortality* (2014) p. 31.
[160] Ariel Frisancho Arroyo, National Coordinator of Social Rights' Programs - CARE Peru, *Citizen Monitoring to Promote the Right to Health Care and Accountability* (2013).
[161] Vanessa Barbara, Opinion: *Latin America Claims to Love Its Mothers. Why Does It Abuse Them?*, The New York Times (March 11, 2019). *See also* Williams CR, Jerez C, Klein K, Correa M, Belizan JM, Cormick G. Obstetric violence: a Latin American legal response to mistreatment during childbirth. BJOG 2018;125:1208–1211.
[162] Williams CR, Jerez C, Klein K, Correa M, Belizan JM, Cormick G. Obstetric violence: a Latin American legal response to mistreatment during childbirth. BJOG 2018;125:1208–1211.
[163] *Id.*
[164] *Id.*
[165] Organization of American States, *Sexual and Reproductive Rights: Obstetric Violence*, available at https://www.oas.org/es/mesecvi/docs/Infografia-Derechos-EN.pdf.
[166] Williams CR, Jerez C, Klein K, Correa M, Belizan JM, Cormick G. Obstetric violence: a Latin American legal response to mistreatment during childbirth. BJOG 2018;125:1208–1211.
[167] *Id.*
[168] Sadler et al., *Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence*, Reproductive Health Matters (2016), p. 50.

[170] *Laxmi Mandal & Ors v Deen Dazal Harinagar Hospital & Ors*. W.P. (C) 8853/2008
[171] International Federation of Gynecology and Obstetrics (FIGO) Committee for the Ethical Aspects of Human Reproductive and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (Oct. 2015), pgs. 28-32.

[172] International Federation of Gynecology and Obstetrics (FIGO) Committee for the Ethical Aspects of Human Reproductive and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (Oct. 2015), pgs. 28-32.
[173] On health systems response to intimate partner violence and sexual violence, see guidance from WHO, *Responding to intimate partner violence and sexual violence against women*
WHO clinical and policy guidelines (2013); WHO, *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers* (2017).

[174] 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*, U.N. Doc. A/HRC/21/22 (2012), pgs. 4-8.
[175] Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018), p. 12-14.
[176] *Id.* at para. 66.
[177] 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*, U.N. Doc. A/HRC/21/22 (2012), p. 17.
[178]*Id*..
[179] *Id.* at pgs. 11-14.