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Obstetric Violence as Violence Against Women

A Focus on South America

Supervisor
Ch. Prof. Sara De Vido
Assistant supervisor
Ch. Prof. Luis Fernando Beneduzi

Graduand
Laura Zazzaron
836492

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Contents

INTRODUCTION

Obstetric violence is considered as a particular type of mistreatment towards pregnant women during their pregnancy, labour time and postpartum care by doctors, nurses and health personnel in general. It can hurt physically, mentally and psychologically and can occurs in both public hospital and private health facilities. It takes different forms such as physical violence or verbal abuse.

Even though it has been performed for decades in many maternity wards all around the world, it has been recognised under the name of obstetric violence only in the last decade, most precisely since 2007 when the first national law recognised it.

The focus of the study is on Latin America because, up to today, it is the only region of the world where countries have typified it in their national law. Some of them (Venezuela in 2007, Argentina in 2009 and some states of Mexico since 2008) have also recognised it as a crime therefore it is possible to find it in their penal code and be persecuted for it.

This study will especially try to understand whether obstetric violence can be considered as a type of violence against women. It also investigates whether obstetric violence can be considered as institutional violence, and a violation of women's human rights. In this case, which human rights are violated and in which binding and non-binding instruments these rights are recognised.

Finally, the study will identify the most relevant precedents of international judgments which show a breach in international and regional documents to understand if obstetric violence can be judged as violence. These are the most important questions this study will try to answer. To do so, different characteristics are taken into consideration and analysed in five different chapters.

The first chapter gives a definition of obstetric violence, identifying the main actors involved in the violence and gives an overview of the history of women both in the field of medicine and as patients under the raise of patriarchy and of the history of obstetric violence since the 50s up to today's characteristics. Subsequently, there is a presentation of the various forms that obstetric violence can take, divided in physical and psychological mistreatments. Obstetric violence will be also studied from a medical point of view and the main physical procedures which are often use in the maternity wards all around the world are criticised according to their dangerousness. A brief section on the mental impact obstetric violence can have on women who are victims will follow.

Obstetric violence will be later studied from the point of view of human rights to see if it can be considered as a violation of reproductive rights. For this reason, a section is dedicated to the most important stages in the history of the recognition of reproductive rights. A special focus will be given to the MDGs and SDGs Agendas and the role reproductive rights have on them.

Lastly, to conclude the overview of obstetric violence, a section is dedicated to the social and political contexts in which the laws which typified this type of violence have been adopted.

The second chapter relies on the legal framework of obstetric violence. At international level there is no recognition of this type of violence therefore no international legal documents include it. Nevertheless, there is a supporting body of articles in conventions and declarations which rule the field of health. This chapter is divided into three levels. The first one is dedicated to the international legal framework, the second one to the regional (Latin America) instruments and finally, the third section to the national laws which includes obstetric violence. Until now, only six countries have typified it in their laws and only three of them have recognised it as a crime. The last section of the chapter listed the new countries that in the last few years have added obstetric violence in their law against violence against women.

The third chapter will list the human rights that can be violated through obstetric violence. For each human right, it is given the main international and regional instruments where it is possible to find the articles which regulate it. A brief section will give an overview of the right to maternal care and what it includes. Lately, the focus shifted to the main characteristics of institutional violence, what includes and the principles which regulate the action of health personnel. Lastly, the concept of intersectionality is introduced. This concept applies to many cases of obstetric violence as well as in many cases of violence against women, where victims are discriminated on the basis of two or more discriminative basis. As clear alongside the whole study, the major victims of obstetric violence are Indigenous women, women from the poorest sectors of the population and/or women from rural areas.

In chapter four, obstetric violence is analysed in concrete. There will be given some data and statistics on the actual situation of the countries involved in the study and cases of the violence in the three countries who criminalised its practices. As obstetric violence is not recognised at international level, there cannot be international judgments, nevertheless, many judgments by the Inter-American Court of Human Rights dealt with similar cases. A quick view of the reasons why women victims of such violence do not report it, will follow. To conclude the chapter, there is an explanation of maternal mortality, its causes and consequences and the reason of its importance in the issue.

The last chapter of the study is dedicated to the new projects of law throughout Latin America, many of them will probably be approved in the next months. And finally, the last section is dedicated to some of the most important national plans and actions which have been taken in the last years to

improve their health services and to tackle this type of violence, by the countries which recognised obstetric violence in their law.

It is right to point out that not all health facilities are carrying out the procedures described in the course of the study in a routine way. Most of the cases are procedures used in case of emergency by professional doctors and obstetricians who do care about the health of the mother and the baby. Despite this, numerous statistics show that in many areas of the world there is an excessive medicalization at the time of delivery with consequences that may have disastrous outcomes as described throughout the chapters. An inverting trend with respect to this is taking place precisely in Latin American where some laws have identified and criminalised this type of violence. Latin America is witnessing also the birth and growth of several organizations for the spread of knowledge and information regarding the problem. Moreover, all over the globe, and not only in Latin America, there are projects of law in the parliaments seeking the promotion of a more humanised birth, according to the times and the physiological needs of each woman and child.

Chapter 1. Obstetric violence and reproductive rights

Contents: 1. What is obstetric violence?; 1.1 History of Women dealing with obstetric care before the 50s; 1.2 Obstetric violence since the 50s up to today; 1.2 Different types of obstetric violence; 2. Why is obstetric violence so dangerous? A medical perspective; 2.1 Physical practices; 2.2 Mental impact of obstetric violence; 3. Women in subordinate position led to obstetric violence or the reverse?; 3.1 A social and historic overview of women in subordination in the medicine field; 3.2Today's characteristics; 4. Reproductive rights; An historic overview; 4.1 Reproductive Rights (not) in the MDGs but in the SDGs Agenda; 5. Historical and social context

This first chapter aims to give a definition and clarify the concept of obstetric violence, the acts and procedures which can be part of it and the differs types it can be divided in. From one hand, the dangers of obstetric violence will be analysed under a medical perspective, focusing on the main physical procedures which, in specific contexts of over medicalisation, can be considered as obstetric violence and the psychological impact they can have on women. On the other hand, the section will focus on obstetric violence linked to the position of women in the health care. Being obstetric violence a cause of the violation of reproductive rights, it is necessary to include them in the study. Thus, in the following section, there will be a brief overview of the history of reproductive rights with a focus on their inclusion in the MDGs Agenda. Lastly, the historic context which led to the adoption of the laws in which obstetric violence is included will be analysed.

1. What is obstetric violence?

"Come on, you need to open your legs, obviously you didn't mind that nine months ago"
"You screamed of pleasure when you did, now it's time for you to scream of pain"
"If you liked the sweetness now stand the bitterness" [1]
So hard to believe that these sentences could have been said in different languages all around the world, in a lot of delivery rooms, often screamed to women during what is supposed to be one of the most joyful and fulfilling time in a woman's life.
Harsh sentences like these, together with coercive practices and other inhumane treatments are all practices recollected under the umbrella of obstetric violence.
This kind of violence, which would be extremely disrespectful on a normal day, is even more dangerous due to the peculiar physically, socially, and psychologically period, pregnant women are living.

[1] Bellón Sanchéz Silvia. (2014). Obstetric Violence. Medicalization, authority and sexism within Spanish obstetric assistance (Master's degree thesis, Utrecht University, Netherlands and Universidad de Granada, Spain), p. 23

As reported by the WHO in 2015, a large number of women around the world experience disrespectful and abusive treatment during childbirth in facilities.[2] This treatment has assumed different labelling over the years until the last decade when there is a more international trend towards the use of the lemma of "obstetric violence".

The first definition of obstetric violence came from a law entered into force in March 2007 in Venezuela. The Organic Law on the Right of Women to a Life Free of Violence at its article 15(13), defines obstetric violence as:

"[...] the appropriation of a woman's body and reproductive processes by health personnel, in the form of dehumanizing treatment, abusive medicalization and pathologization of natural processes, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women." [3]

Obstetric violence consists then in any act, behaviour or omission, by health personnel which directly or indirectly affects the body and the reproductive processes of women. It can occur in both public and private health care facilities during obstetric care and can either physically or psychologically harm a woman at any time during her pregnancy, birth and postpartum period. Obstetric violence can be performed in a number of different way: through a lack of access to reproductive health facilities, through an overuse of medical intervention during the processes and through a cruel, inhumane or degrading treatment. This general disrespect toward the labouring woman, results in an undermining of her right and ability to make autonomous decision about her reproductive processes.

All pregnant women can be victims of obstetric violence. Pregnancy is the term used to describe the period in which a foetus develops inside a woman's uterus and it usually lasts 40 weeks. Nevertheless, a woman is still at risk of pregnancy-related problems within 42 days of termination of pregnancy. Postpartum health problems can include infections, excessive bleeding, poor bladder control in case of a vaginal birth, among others. This means that obstetric care can be required also immediately after the delivery up to about 6 weeks after it. In fact, women should be closely monitored during the immediate postpartum period, reassessing her clinical status and documenting their conditions.[4]

Taking care of pregnant women there are gynaecologists and obstetricians. But not only. All health personnel, from first aid assistants to medical students and in many cases nurses, can commit obstetric

[2] WHO. (2015). The prevention and elimination of disrespect and abuse during facility-based childbirth. Geneva, Switzerland. Retrieved from http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1 p. 1

[3] Gaceta Oficial No. 40.548 de la República Bolivariana de Venezuela, Ley Orgánica Sobre el Derecho de Las Mujeres a una Vida Libre de Violencia. Caracas, Venezuela, April 23, 2007. Available at http://www.derechos.org.ve/pw/wp-content/uploads/11.-Ley-Org%C3%A1nica-sobre-el-Derecho-de-las-Mujeres-a-una-Vida-Libre-de-Violencia.pdf

[4] CONAMED. (2012). Recomendaciones Generales para Mejorar la Calidad de la Atención Obstétrica. México, p. 7. Retrieved from http://www.conamed.gob.mx/prof_salud/pdf/RECOM_obstetricia_web.pdf p. 7

violence and have their part in performing it either materially or with their silence. When they take active part, they can refuse to administer pain relief or other medications as well as water or food to the woman. A typical form of abuse they perform is the verbal one, judging outcomes or trivialising the procedures.

When talking about obstetric violence, it is necessary to keep in mind that not in all health facilities there are cases of obstetric violence. Nevertheless, in many of them, there is a negative custom to mistreat pregnant women for different reasons. Studies on why obstetric violence exist[5], approached the problem of obstetric violence as a problem of the quality of attention in health facilities. The problems sort out because of the difficult work conditions of health personnel. That includes, among other reasons, the great number of people that arrive to the facilities and have to be attended, long shift hours and low resources available in the facilities (i.e. syringes, tools, minimum of essential medicines as prescribed by the WHO in the WHO model list of essential medicines).

1.1 History of Women dealing with obstetric care before the 50s

Until the Middle Age, women used to take care of other women when the latter were pregnant. No person was better to take care of such a delicate period in a woman's life than another woman who perhaps had already passed the joy of a pregnancy and the pain of a delivery.

But it is during the Middle Ages that men, who had already the control of the field of medicine, started taking more and more authority in assisting childbirth.

In fact, during those years, men have exclusive access to education and the field of gynaecology and obstetrician begins to be studied and practiced by males.

At first, midwives were used as intermediaries between physicians and the patients to overcome the problem of a man taking care of women's sexuality. In doing so, midwives started then to be relegated to a position of subordination until the point that performing their job was really difficult due to new regulations on the field. Despite the great effort of midwives to safeguard their work, they eventually had to witness the slow decline of their presence in the field of gynaecology and obstetrics to make room for a greater presence of men in their place and assist at their job becoming part of the male scientific practice.[6]

[5] See for example Castro R., Joaquina Erviti. Disrespectful and abusive treatment, 2015 and Sadler M., Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. 2003

[6] Bellón Sanchéz Silvia. (2014). Obstetric Violence. Medicalization, authority and sexism within Spanish obstetric assistance (Master's degree thesis, Utrecht University, Netherlands and Universidad de Granada, Spain), pp. 32-34

1.2 Obstetric violence since the 50s up to today

Even when still there was no unanimous word for such aberrant procedure, obstetric violence was performed at all levels. The first clue of what would have been later known as obstetric violence dates back in 1958. An article entitled "Cruelty in Maternity Wards" was published by the Ladies' Home Journal, an American magazine considered among the most important women's magazines of the 20th century in the United States. The article told tales about the inhumane treatments women received during their labour in public health facilities.

The article had an enormous impact on public opinion and even succeeded in putting forward the rights of pregnant women begging the movement that allow husband to be present during the labour time of their wives into maternity wards to help their life companions and share the experience of first moments of life of their baby. The investigative report began from a letter sent to the journal by an anonymous "registered nurse'' who denounced the mistreatments in her health facilities and asked, or better, begged the journal to "investigate the tortures that go on in modern delivery rooms". After the letter, the journal received hundreds and hundreds of letters from readers denouncing their mistreatment at the time they were giving births in the delivering rooms all around the country. The journal received even letters containing confessions from nurses who, fearing to lose their job if they were to speak up, allowed with their tacit consensus to the mistreatments. To confirm the confessions, another anonymous letter from an obstetrician described the cruel treatments women had to undergo during delivery.[7]

50 years later and in certain cases, things seem not to have changed so much.

After the revelations of the mistreatments, however, we would have noticed no immediate significant improvement in pregnancy, childbirth, and postpartum healthcare. We must wait until the mid-60s when feminist movements arouse gained more and more power and voice. Rights of pregnant women started finally have the attention they deserve.

From the 50s onwards, childbirth has started to be seen as a dangerous event in woman's life and the safest place to give birth switched from being the pregnant woman's home to the hospital. As time went on, also the mere help of professionals became more and more essential interventionism until the point that pregnancy started to be considered from a pathological point of view and so, as a pathology to take care of and cure. From this perspective, even normal pregnancies with no complications and then no subject to any medical interventions, are treated like sequelae in need of a

[7] Goer, H. (2010). Cruelty in Maternity Wards: Fifty Years Later. The Journal of Perinatal Education, vol. 19(3), pp. 33–42. Available at http://doi.org/10.1624/105812410X514413

medical intervention. And the moment of the deliver, a moment so natural during a woman's life began to be perceived as dangerous if performed alone and in need of a specialist.[8]

In this regard, professor and pioneer of obstetric violence as a violation of sexual and reproductive rights Marbella Camacaro Cuevas, forged the sentence "patologizando lo natural, naturalizando lo patológico" (pathologizing the natural, naturalising the pathologic) to better resume the issue. That is, the idea that delivery is seen as an illness to be treated, eventually considering natural to perform a C-sections or episiotomy when it is not. As Camacaro argues, women are nowadays subjected to procedures that have negative consequences for their health. This is not only because of the treatments itself but for the mere fact that women are treated as sick when they are not. Medical interventions then become the normality and, in doing so, women lose their ability to do it by themselves.[9]

Therefore nowadays, many women consider normal when doctors hurry their deliveries performing C-sections with no medical necessity. But high rates of C-sections and episiotomy are exactly the contrary of what medical recommendations and the WHO's guidelines suggest.

1.3 Different types of obstetric violence

There are there are many practices which can be catalogued as obstetric violence and they can take place during the pre-partum care, delivery, postpartum care and including during the first stages of childbearing. Especially, in the following 6 weeks after the birth.

Obstetric violence can be manifested through verbal humiliations, discrimination or humiliation based on race, ethnic or economic background, age, HIV status, among others.

As reported by a document by GIRE [10] the manifestations of obstetric violence can include: "[…] scolding, taunts, irony, insults, threats, humiliation, manipulation of information and denial of treatment, not providing referrals to other services in order to receive timely assistance, delaying urgent medical care, indifference to women's requests or complaints, failure to inform or ask women about decisions made during the various stages of labour, use of women for didactic purposes without any respect for their dignity, pain management during childbirth used as punishment, and coercion to obtain "consent", and finally, even acts of deliberate harm to a woman's health, among even more serious and obvious violations of their human rights."[11]

[8] Machado M. (2014). ¿Cómo parimos? De la violencia obstétrica al parto humanizado. (Thesis at Universidad de la República, Uruguay), section 2 Retrieved from http://sifp1.psico.edu.uy/sites/default/files/Trabajos%20finales/%20Archivos/trabajo_final_grado_machado.pdf

[9] Marbella Camacaro Cuevas. (2009). Patologizando lo Natural, Naturalizando lo Patológico. Improntas de la Praxis Obstétrica. Revista Venezolana De Estudios De La Mujer, vol. 14(32). Caracas, Venezuela, pp. 154-161

[10] GIRE, Fundación Angélica Fuente. (November 2015). Obstetric Violence. A Human Rights Approach., p. 13. Retrieved from ire.org.mx/en/wp-content/uploads/sites/2/2015/11/ObstetricViolenceReport.pdf

[11] Villanueva-Egan L.A. (2010). El maltrato en las salas de parto: reflexiones de un gineco-obstetra. Revista CONAMED, vol. 15, No. 3, July-September 2010, p. 148. Available at http://bit.ly/hF16fY

Mistreatments can be divided into physical and psychological:[12]

Physical mistreatment means any invasive practice performed on the woman, the disregard of a woman's needs and pain, the denial of treatment or, at the contrary, the abuse of unnecessary medicalisation which includes all procedures which are not essential from the medical point of view or which are not clinically justified to enhance the health of either the woman and the baby.

The most common medical interventions not considered as essential and even classified as dangerous by the WHO are: the use of oxytocin to induce labour, enemas, shaving of pubic hair, the Kristeller manoeuvre, episiotomy, unnecessary C-sections, repeated vaginal exams by different medical staff and/or by different apprentice students, the prohibition to have a family member into the birthing rooms at the time of the delivery, the fact of not providing information and not asking for consent on procedures, the obligation of the supine position during the delivery and the prohibition to freely move during the delivery.

Physical abuse includes also any actions involving the use of force (e.g. physical restraint, the beating, slapping, kicking, pinching of women during delivery, the physical restrain of women to the bed during delivery, the forced medical detention in health facilities for failing to pay, medical interventions without the informed consensus of the mother among other dehumanizing and rude treatments). Medical interventions carried out without informed consent happen when the parturient neglect and/or is not informed before the performance of the procedure. This represents a severe violation of the right to information as well as it undermines the freedom of choice of the woman.

On the other side, obstetric violence has a great impact on the psychological sphere, too. It happens when a woman is criticised for crying during labour, screaming because of the pain and also for being afraid and asking for questions and doubts. Dehumanising practices include mocking comments, humiliations, discrimination, judgments, ironic remarks, trivialisation of the explanations, miscarrying attitude, calling by nicknames, in general the addressing of the woman as a child, refusing the administration of pain relief or anaesthesia even when asked, preventing early attachment to the child even if not medically necessary.

In these cases, obstetric violence is performed through the use of harsh and rude language, threats, and blaming for poor outcome by doctors, nurses and general health personnel. Even though this kind of abuse might appear less intense, it is very denigrating due to the mental conditions of stress and nervousness a woman experience during such an important period of her life.

[12] GIRE. Niñas y mujeres sin justicia. (2015). Derechos reproductivos en México. Mexico, p. 124. Retrieved from https://gire.org.mx/wp-content/uploads/2016/07/INFORME-GIRE-2015.pdf

This main division of obstetric violence in physical and psychological has been recollected by many organizations and association which promote a safe and natural birth. As a matter of fact, further studies[13] have later broaden the spectrum of mistreatments involved.

For example, a deeper subdivision of the different types of obstetric violence has been developed by Bohren et al in 2015.[14] Obstetric violence is synthesized in seven different types of mistreatment. Apart from physical abuse and verbal abuse, Bohren added sexual abuse; stigma and discrimination; failure to meet professional standards of care; poor rapport between women and providers; and health system conditions and constraints. Grouped underneath each of these higher-order categories are several more specific elements. [15]

While stigma and discrimination behaviours are connected to the cultural factor, the failure to meet professional standards of care includes, among other mistreatments already listed above, the lack of informed consent and a breach on the confidentiality, the denial of information about the procedures employed during the labour process, the abandonment of the pregnant woman or long delays and skilled attendant absent at time of delivery.[16]

Finally, with respect to the poor rapport between women and providers, the same study asserts the hypothesis of an ineffective communication, a lack of supportive care and a loss of autonomy which take the shape of attitudes like "poor communication, dismissal of women's concerns, language and interpretation issues, poor staff attitudes, lack of supportive care from health workers, denial or lack of birth companions, women treated as passive participants during childbirth, denial of food, fluids or mobility, lack of respect for women's preferred birth positions, denial of safe traditional practices, objectification of women, and detainment in health facilities for different reasons. This last case is common above all in some countries of Africa.[17] Health staff usually detain women in facilities until their families are able to pay for the care they received. This conduct violates many rights protected by international law such as the right to be subjected to cruel, inhuman, or degrading treatment, liberty and security, not to be detained for non-payment of debt among others.[18]

[13] Bohren MA., Vogel JP., Hunter EC. et al. (30 June 2015). The Mistreatment of Women during Childbirth in Health Facilities Globally. A Mixed-Methods Systematic Review. PLoS Med 12(6), p. 7

[14] Ibid.

[15] Madeira S., Pileggi V., Souza J.P. (2017). Abuse and disrespect in childbirth process and abortion situation in Latin America and the Caribbean - systematic review protocol, additional file No. 1 table 1 "Types of abuse and disrespect of women in the process of delivery and/or abortion." Systematic Reviews, 6, 152. http://doi.org/10.1186/s13643-017-0516-5

[16] Bohren MA., Vogel JP., Hunter EC. et al. (30 June 2015). The Mistreatment of Women during Childbirth in Health Facilities Globally. A Mixed-Methods Systematic Review. PLoS Med 12(6), p. 7.

[17] Center for Reproductive Rights and Federation of Women Lawyers–Kenya. (2007). Failure to Deliver. Violations of Women's Human Rights in Kenyan Health Facilities. Retrieved from https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf

[18] Ibid. pp. 56-59

2. Why is obstetric violence so dangerous? A medical perspective

Obstetric violence can have a huge impact on both the physical and mental health of a woman. Listed in the section, there are some of the main procedures obstetrics and gynaecologists can perform on a pregnant woman. As explained, not all of them are been proved to actually help the mum and the foetus during labour. On the contrary, they are often the main causes of following health problems. All the procedures listed below can be considered as acts of obstetric violence when they are performed without consensus from the woman or when they are used with no medical justification, for example in order to accelerate a labour and thus neglecting the possibility to have a natural vaginal delivery.

2.1 Physical practices

Many physical practices which are often or usually performed to induce or to accelerate a birth, are considered as dangerous by the WHO.[19]

Perhaps the most common practice performed during a woman's labour is the practice of episiotomy. The first episiotomy was performed in 1742, in order to make deliveries easier for women.[20] Since then, it use has been increased until being considered as routine practice in many health facilities.

The episiotomy is a surgical incision into the perineum (the muscles around the area between the vagina and anus) during the second stage of labour to expand the opening of the vaginal opening, to prevent its laceration and the tearing of the perineum and the surrounding tissues during the delivery of the baby and to make the same delivery easier.[21] Indeed, it may have some positive aspects, for example, it releases pressure on the foetal head during birth.[22] However, the reasons why an episiotomy should be performed are strictly medical. Among other reasons, it can be required in case of maternal or foetal distress and there is not enough time to allow the perineum to completely stretch to allow the child to safely exit; when the mother is tired and not able to push enough anymore; when the baby is premature or in the wrong position or when it is diagnosed with foetal macrosomia (the baby is larger than the average).[23] In the last case, delivering without intervention could cause

[19] Episiotomy. The cruellest cut? (1 December 2017). Retrieved 15 January 2018, from https://www.pressreader.com/south-africa/your-pregnancy/20171201/283085594402236

[20] Lappen J. R., Gossett D. R. (2010). Changes in Episiotomy Practice. Evidence-based Medicine in Action. Expert Rev of Obstet Gynecol., vol.5(3), pp. 301-309.

[21] Collins. (2018). [online] at: https://www.collinsdictionary.com/dictionary/english/episiotomy [Accessed 15 Jan. 2018].

[22] Pillitteri A. (2010). Maternal & Child Health Nursing. Care of the Childbearing & Childrearing Family. Lippincott Williams & Wilkins, p. 562. 2

[23] Viswanathan M, Hartmann K, Palmieri R, et al. The Use of Episiotomy in Obstetrical Care: A Systematic Review: Summary. May 2005. In: AHRQ Evidence Report Summaries. Rockville (MD): Agency for Healthcare Research and Quality (US); 1998-2005. 112. Available from: https://www.ncbi.nlm.nih.gov/books/NBK11967/ and WHO, Care in Normal Birth. A Practical Guide. 1996, p. 28

damages to the baby's head because the perineum is too much tight to permit a natural birth.[24] As clear, episiotomy is a practice which has to be used in some specific cases requiring medical intervention. Nevertheless, some experts believe than the practice of episiotomy helps the mum giving birth, accelerating the whole process and making it easier for the baby, too.[25]

It has been scientifically proved almost 30 years ago that it does not help women giving birth at all. On the contrary, when the cutting reaches the anus, it brings a lot of pain, including during later sexual relations, and urinary and faecal incontinence among other problems.[26]

And many later reports have confirmed that there are no benefits from episiotomy.[27] On the contrary, "the routine use of this procedure is harmful inasmuch the same proportion of women who would have had lesser injury instead had a surgical incision."[28]

Even the WHO recall that "the systematic use of episiotomy is not justified. And it also added that "the protection of the perineum through alternative methods should be always evaluated and adopted."[29]

Even though there has been a decrease in the rate of episiotomy throughout the last century, today's rate is still too much high according to the average ratio of 10% given by the WHO[30]. It is necessary to say, however, that the incidence of episiotomy performed is not the same throughout the world. The rate considerably varies according to the country. For example, the rate of episiotomies performed in the USA is 62.50% whilst in Europe it is less than half (30% throughout the continent and it drops as low as 9.70% in Sweden). In Taiwan the rate is 100%.[31]

As Marsden Wagner, the former Director of Women's and Children's Health for the WHO [32], declared referring to the situation in Spain "performing too many episiotomies has accurately been tagged as another form of genital mutilation on women […]. The rate of 89% in Spain is a scandal and a tragedy." After his declaration, the rate of episiotomy in Spain dramatically reduced. Nevertheless,

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[24] WHO. (1996). Care in Normal Birth. A Practical Guide. Geneva, Switzerland. Retrieved from http://www.who.int/maternal_child_adolescent/documents/who_frh_msm_9624/en/ p. 29

[25] See for example data in Hong Jiang, Xu Qian, Carroli G. et al., Selective versus routine use of episiotomy for vaginal birth. The Cochrane Database of Systematic Reviews, (2), 2017. CD000081. Advance online publication. http://doi.org/10.1002/14651858.CD000081.pub3

[26] NHS. (2017). Episiotomy and perineal tears. Available at https://www.nhs.uk/conditions/pregnancy-and-baby/episiotomy/?? Retrieved 15 January 2018

[27] Gün İ., Doğan B., Özdamar Ö. (2016). Long- and short-term complications of episiotomy in Turkish Journal of Obstetrics and Gynecology, 13(3). pp. 144–148.

[28] Hartmann K., Viswanathan M., Palmieri R., et al. (4 May 2005). Gartlehner G, Thorp J, Lohr KN. Outcomes of Routine Episiotomy. A Systematic Review. JAMA vol 293(17), p. 7.

[29] WHO. (24 August 1985). Appropriate technology for birth. Lancet. Volume 326, Issue 8452, pp. 436–437

[30] Ibid at 24, p. 29

[31] Ibid p. 9

[32] Marsden Wagner served as Director of Women's and Children's Health for the WHO for 15 years during which time he chaired the three consensus conferences convened by WHO on appropriate technology around the time of birth.

the new rate is considered still too high. More recent researches keep presenting further evidence against the frequent use of episiotomy[33] and that episiotomy should be avoided if at all possible.[34]

Secondly, the Caesarean or C-section is probably the most criticised birth method both for the physical pain, later complications, long-term issues, and for the measures to adopt after the surgery. Some of the countries with less perinatal mortality show less than 10% of C-sections.[35] When C-section rates in a country are around 10%, there is a significant decrease in maternal and new-born deaths. But when the rate is over 10%, there is no evidence that death rates improve.[36] So, it is not justifiable to have a higher rate than 10-15% as recommended by the WHO in its Guidelines.[37] In addition to that, it is not proved that after a C-section, a woman must go through a C-section again. It is possible and recommended to give a vaginal birth even though in 90% of the cases, women will give subsequent births by C-section as well.[38] According to the most recent data, the average rate of C-section in the world is 18.6%. It ranges from 6.0% to 27.2% according to the regions. The lowest rates are found in Africa (7.3%) whilst the highest are found in Latin American and the Caribbean (40.5%). South America is the sub region with the highest average rates in the world (42.9%). Brazil for example has a rate of C-section of 55.6%.[39]

Thirdly, the uterine fundal pressure, better known as Kristeller manoeuvre from the name of Samuel Kristeller, a Berlin obstetrician who in 1867 created such procedure. [40]
The manoeuvre consists in pushing down on the top of the uterus in order to accelerate the expulsion. The same Kristeller has described it as "an aid in weak uterine contractions" at the time of expulsion (second stage of delivery).[41]Apart from being a painful manoeuvre for the mum, it can be dangerous for the uterus, the perineum and the same foetus which can suffer from severe damages because of the unnatural pushing.[42] According to a research published in the Central European Journal of

[33] See foe example Klein, M, Gauthier, R, Jorgensen, S et al. Does episiotomy prevent perineal trauma and pelvic floor relaxation? 1992
[34] Berghella V. (2012). Obstetric Evidence Based Guidelines. NY: Taylor & Francis Group, p. 79
[35] WHO. (2015). Statement on caesarean section rates. Geneva, Switzerland. Retrieved from http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/, p. 3
[36] Ibid.
[37] Ibid.
[38] The New York Times, August 28, 2017. Last accessed 15 January 2018. Retrieved at https://opinionator.blogs.nytimes.com/2016/01/19/arsdarian-cutting-the-number-of-c-section-births/
[39] Betrán P., Ye, Moller at al. (February 5, 2016). The Increasing Trend in Caesarean Section Rates: Global, Regional and National Estimates: 1990-2014. Retrieved at http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0148343
[40] Waszyński E. (2008). Kristeller's procedure. Expressio fetus, its genesis and contemporary application in Ginekol Pol. Apr;79 (4), pp.297-300
[41] Dubravko Habek, Mirna Vuković Bobić, Zlatko Hrgović. (2008). Possible feto-maternal clinical risk of the Kristeller's expression in Central European Journal of Medicine, vol. 3(2), pp. 183-186
[42] Miles Chile. (December 2016). Primer Informe Salud Sexual Salud Reproductiva y Derechos Humanos en Chile. Estado de la situación 2016, pp. 233-234. Retrieved from http://www.mileschile.cl/documentos/Informe_DDSSRR_2016_Miles.pdf pp. 233-234

Medicine[43] "in line with the principles of modern obstetrics, Kristeller manoeuvre should be reserved for the specific rare cases in case of large child or other critical medical conditions therefore its use can be avoided in the majority of cases."

Source of argument is also the use of synthetic oxytocin. Oxytocin, also known as the love hormone, causes uterine contractions and then it is used to induce labour. This intervention is considered by the WHO as a mayor intervention due to the side effects and dangers its use involves. For these reasons, it should be used only under specific indication. Some of the risks it involves are: uterine rupture, a higher rate of C-section and use of forceps, more pain for the woman and so a mayor need for pain relief, and severe foetal distress.[44]

Another focal point concerns the position to adopt during the delivery. The WHO does not recommend placing the pregnant woman on a lithotomy position (dorsal position) during the dilation of cervix and during the delivery.[45] The lithotomy position is the general position gynaecologists and obstetricians use during their medical examinations: the woman lies on her back with her thighs open and the legs flexed and supported in raised stirrups. Even though this position provides excellent surgical access to the perineum, it is preferable to walk during the dilatation and every woman should be free to decide the position that best fits for the delivering.[46]

Other important procedures which are often performed to induce labour are the amniotomy or the artificial rupture of membranes (AROM), foetal monitorization, enemas and pubic shaving.
The artificial rupture of membranes or amniotomy consists in deliberately break the amniotic sac in order to release the amniotic fluid and accelerate the birth.[47] In normal labour there should not be a necessity for interfering with the artificial rupture of membranes.[48]
For what concern foetal monitorization, as outlined by a research made by FIGO (International Federation of Gynaecology and Obstetrics)[49] there is no evidence that the routine foetal monitorization has a positive effect and it should be carried out only under specific circumstances.
Finally, an enema is the injection of a liquid or a gas into the rectum to empty their bowels. It is believed that reduces the possibility of an infection and, at the same time, makes space for the baby

[43] Ibid. at 41
[44] Ibid at 42
[45] Ibid.
[46] Ibid.
[47] O'Connell N. G., Walker B. L. (2016). Amniotomy Technique. Retrieved from https://emedicine.medscape.com/article/1997932-technique
[48] Ibid at 42
[49] Ayres-de-Campos D., Spong C.Y., Chandraharan E. FIGO consensus guidelines on intrapartum foetal monitoring. Int J Gynaecol Obstet. 2015 Oct;131(1):13-24., p.4

at the moment of labour. On the contrary, enemas have no salutary effects and that is the reason why it is convenient to cut the rate of enemas performed.[50] Enemas cause increased pain during labour and even could potentially increase the risk of infections and have no significant benefits on infection rates such as perineal wound infection or other neonatal infections and women's satisfaction.[51] According to the WHO, enemas have no result on preventing infections of perinatal wound and other neonatal infections therefore the habit of enemas, as well as other practices must be limited.[52] Pubic shaving has no resulted in preventing infections, either, on the contrary, it increases the risk of infection as micro abrasions resulting from the shaving can generate infections.[53]

2.2 Mental impact of obstetric violence

Apart from the physical procedures which can be involved in obstetric violence, the psychological sphere plays an important role in women's health during and after labour. Mistreatments as listed above can contribute to many mental disorders with negative effects on the health of both the mum and the new-born. In particular, it can cause post-traumatic stress disorder [54] and postpartum depression.

As shown in a Brazilian study published in 2017 [55] aimed to investigate the association between institutional violence in obstetrics and postpartum depression, there is an actual direct link between "mistreatment and adverse maternal, perinatal and infant outcomes in the same birth. In particular, mistreatment may contribute to maternal postpartum depression and post-traumatic stress disorder, particularly in cases of extreme abuse. Mistreatment may also be associated with decreased rates of breastfeeding initiation."

The study continues identifying the correlation between the quality of the obstetric care received during puerperal period and some psychiatric disorders that can arise, namely postpartum depression. Elements that can affect such disorders are, as listed in the article, "the feeling of abandonment during delivery, inadequate pain management, frustration for having delivered via caesarean section when natural childbirth was possible, and the pregnant woman's perception of the team who provided the care". Women who experienced mistreatment during maternal care, either physical or verbal, are

[50] Ibid at 42

[51] Reveiz L., Gaitán H. G., Cuervo L.G. (2013). Enemas during labour, p. 2. Available at http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000330.pub4/epdf

[52] Ibid at 42

[53] WHO. (1996). Care in Normal Birth. A Practical Guide. Geneva, Switzerland. Retrieved from http://www.who.int/maternal_child_adolescent/documents/who_frh_msm_9624/en/ p. 8

[54] Ibone Olga Fernandéz. (2014). Estrés postraumático secundario en profesionales de la atención al parto. Aproximación al concepto de violencia obstétrica in C. Med. Psicosom, Nº 111, 2014, pp. 79-83

[55] Junqueira de Souza K., Rattner D., Bauermann Gubert M. (2017). Institutional violence and quality of service in obstetrics are associated with postpartum depression. Revista de Saúde Pública da Universidade de São Paulo, pp. 51-69.

seven times more at risk of developing postpartum depression compared to women who did not suffered any mistreatment.[56]

Another important outcome in the psychological field is that obstetric violence can influence women's decision not to choose hospital facilities for their subsequent pregnancies and swift to a home birth. This increases the risks associated to the performance of labours and deliveries without the assistance of a trained and skilled birth attendant. A birth without assistance can have either positive and negative outcomes depending on many factors but even in presence of a normal pregnancy, many factors can lead to an emergency during the delivery.

2.3 Women in subordination in the medical field

For many years, the control over women's bodies has been a key point to maintain women in subordinate position.[57] The major part of the society and, within it, the social relations are erected in a patriarchal way. The term "patriarchy" used to refer to the nuclear family organisation which presented a patriarch, a man, as head of the whole family and under his guide, the wife, children and various relatives more. Nowadays the acceptation of patriarchy is used "to refer to male domination, to the power relationships by which men dominate women, and to characterise a system whereby women are kept subordinate in a number of ways."[58] Roles of patriarchy can be seen in both public and private sector and health facilities are not exempt from them.

In the field of medicine, there has been for ages a huge disproportion between female obstetrics and gynaecologist compared to the total number of male professionals performing the same role. Even though the proportion of women entering medicine had more than doubled since 1980, it is not possible to overlook the difficulties and the delay women could enter medical schools and educated themselves to medical careers until some years ago. It was only at the end of the XIX century[59] that the first women from certain countries, managed to enter medical schools and ten years ago, apart from exceptions, "men continued to dominate the medical profession, while other health service providers remained predominantly female".[60] Moreover, "women tended to be concentrated in the

[56] Ibid.

57 Mikkola, Mari. (2017). Feminist Perspectives on Sex and Gender, The Stanford Encyclopaedia of Philosophy, Winter 2017 Edition. Edward N. Zalta (ed.). Available at https://plato.stanford.edu/archives/win2017/entries/feminism-gender/ 2008

[58] Sultana A. (2012). Patriarchy and Women's Subordination: A Theoretical Analysis. Arts Faculty Journal, [S.l.] p. 2

[59] Dr. Elizabeth Blackwell is internationally recognised as the first women who graduated from a medical school in the USA in 1849

[60] WHO. (2006). The World Health Report. Working Together for Health. Geneva, Switzerland, p. 6

lower-status health occupations, and to be a minority among more highly trained professionals."[61] Just in recent years, there has been a trend reversal.

Another point to highlight is the fact that childbirth and motherhood have been seen for centuries as a duty (even not when THE only duty) for a woman.[62]

The WHO estimates that more than 135 million pregnancies occur each year[63], the majority of which being the first child for a woman. Even when a woman is at her second or third pregnancy, the same pregnancy, labour and postpartum period can widely differ from the previous ones for many different reasons such as the age, complicacies and a general broad variety of different factors that can influence the whole pregnancy. As the labour has been so medicalised and due to the fear of complications during birth which is reasonably high, women prefer to rely heavily on a professional as medical staff have been trained to quickly evaluate the problem and have a prompt and effective response for it.

According to the report issued in Mexico in 2013 by GIRE (*Grupo de Información sobre la Reprodución Elegida* - Information Group on Reproductive Choice), Regina Tamés, a Mexican lawyer expert in the field of human rights, reproductive rights and advocacy defines the obstetric violence as "the result of the institutionalization of childbirth when it becomes customary to deliver babies in health centres rather than at home. With this paradigm shift, childbirth cease to be something natural and became a medical practice."

2.4 Today's characteristics

Studies on the issue identified three patterns of behaviour during childbirth which are: "health care personnel using their positions of power and control to intimidate women; women unaccustomed to defending their rights easily accepting the role they are forced into as hospital patients, thereby reflecting and replicating the oppressive situation in which they find themselves; public health institutions, through their structure and mechanisms, discouraging women from pursuing formal complaints."[64]

A patriarchal relationship constitutes the perfect foundation for a possible violation of human rights and can take different forms. For example, the fixed gap role between health care personnel and patient makes that since the very first entry of a pregnant woman to the maternity ward, she has to

[61] Ibid.

[62] Bellón Sanchéz Silvia. (2014). Obstetric Violence. Medicalization, authority and sexism within Spanish obstetric assistance (Master's degree thesis, Utrecht University, Netherlands and Universidad de Granada, Spain), p. 26

[63] WHO. (November 2015). 10 Facts on Maternal Health. Retrieved from http://www.who.int/features/factfiles/maternal_health/en/l

[64] Castro R., Erviti J. (2003), Violations of Reproductive Rights During Hospital Births in México Health and Human Rights Vol. 7, No. 1 (2003), p. 98-105

withstand to what the doctor says or being threatened of severe consequences for her and the baby. "Cooperative" women are better considered among the women who enter the maternity ward but at the same time, they are the easier one to blame in case of complications or poor outcome. If a woman is not "cooperative", doctors can choose from a wide range of tactics to convince her about the necessity for a certain procedure, sometimes using coercion or threat to obtain consent, some others invalidating information and percentages on the procedures.[65]

Others practices that degrade the role of the women during their pregnancy is when the personnel are dismissive about any information or knowledge a woman might have about her condition as well as when they provide little if any information about it. An even more pervasive act is the invalidation of women's suffering which has a direct link on invalidating also women's response and reactions to pain. In correlation with the pain as tribute, many health professionals make inappropriate sexual allusion to the pleasure the woman had during conception and try to put it in correlation of the pain they go through during labour.[66]

Obstetric slang used among doctors in the maternity ward can be disrespectful, too. The most famous example is the so called "husband's stitch".[67] The practice consists in suturing the vaginal opening after a delivery with one or more extra stitches to make the canal tighter. Theoretically, in doing so, husbands will experience more pleasure during future sexual intercourses. Instead, women will experience just more pain and general discomfort.

For different reasons, women usually accept the fact that their rights are being violated, above all for their baby's health. In some cases, they actually justified certain kinds of abuse they received from physicians as "logical". Nevertheless, in doing so, women unknowingly contribute to the mistreatment.[68]

3. Reproductive rights. An historic overview

As obstetric violence undermines women's reproductive rights and health, it is necessary to summarise the most important milestones in the path of reproductive rights under which obstetric violence can find a frame.

Many articles in international tools safeguard the right to health, for example the 1966 International Covenant on Economic, Social and Cultural Rights which at its Article 12(1) states that "[t]he States Parties [...] recognize the right of everyone to the enjoyment of the highest attainable standard of

[65] Ibid. p. 100
[66] Ibid.
[67] Fernández Guillén F. (2015). ¿Qué es la violencia obstétrica? Algunos aspectos sociales, éticos y jurídicos. Dilemata, year 7 No. 18, pp. 113-128, p. 118
[68] Ibid p. 104

physical and mental health.[69]" Nevertheless, the history of reproductive rights started some years and documents later.

In 1948, the Universal Declaration of Human Rights, states at its Article 16(1) that all women and men have the right to found a family without any limitation,[70] right later recollected in Article 23 of the International Covenant on Civil and Political Rights.[71]

The first time we found a mention of what would have been part of the so-called reproductive rights, was in 1968 in the Resolution XVIII on the Human Rights Aspects of Family Planning[72] adopted at the International Conference on Human Rights in Tehran. The Proclamation states that "[...] parents have a basic human right to determine freely and responsibly the number and the spacing of their children and a right to adequate education and information in this respect"[73], right reiterated at the first of the three conferences on population which took place in Bucharest[74], on the paragraph 14 in the Principles and Objectives of the World Population Plan of Action. Only later in 1969, there will be added that "parents have the exclusive right to determine freely and responsibly the number and spacing of their children"[75] underlining the exclusivity of parents to decide about the number of children they wanted and the spacing they preferred.

Considered as an international bill of rights for women, the 1979 the Convention on the Elimination of All Forms of Discrimination against Women[76] at its Article 16(e) reiterates the need of the State to ensure these right on a basis of equality of men and women.

Ten years after the first World Conference on Population in Bucharest, Mexico City hosted the second global conference on population. The 25th recommendation for implementation of the World Population Plan of Action urges governments to make universally available "information, education and the means to assist couples and individuals to achieve their desired number of children."[77] In this

[69] UN General Assembly, International Covenant on Economic, Social and Cultural Rights. 16 December 1966. Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

[70] UN General Assembly, The Universal Declaration of Human Rights. Paris, 10 December 1948. Available at http://www.un.org/en/universal-declaration-human-rights/

[71] UN General Assembly, International Covenant on Civil and Political Rights. 16 December 1966. Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx

[72] UN General Assembly, Final Act of the International Conference on Human Rights, Resolution XVIII. Teheran, Iran 20 December 1968. Available at http http://legal.un.org/avl/pdf/ha/fatchr/Final_Act_of_TehranConf.pdf

[73] UN General Assembly, Resolution XVIII: Human Rights Aspects of Family Planning, Final Act of the International Conference on Human Rights. Tehran, Republic of Iran, 22 April to 13 May 1968. Available at http://legal.un.org/avl/pdf/ha/fatchr/Final_Act_of_TehranConf.pdf

[74] World Conference on Population, World Population Plan of Action. Bucharest, Romania. 19 August 1974 - 30 August 1974. Available at http://www.unfpa.org/sites/default/files/event-pdf/World%20Population%20Plan%20of%20Action_1.pdf

[75] UN General Assembly, Declaration on Social Progress and Development, Article 4. 11 December 1969. Available at http://www.ohchr.org/Documents/ProfessionalInterest/progress.pdf

[76] UN General Assembly, the Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979. Available at http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article12

[77] International Conference on Population. Recommendations for the Further Implementation of the World Population Plan of Action. Mexico City, Mexico, 06 August 1984 - 14 August 1984. Available at http://www.un.org/popin/icpd/conference/bkg/mexrecs.html

regard, the recommendation stated that all type of information, the education and the means about family planning provided by governments should rely on "all medically approved and appropriate methods [...], including natural family planning, to ensure a voluntary and free choice in accordance with changing individual and cultural values." A great emphasis is put on the freedom of women and men to choose the right family plan according to their customs and traditions. The article ended underling the particular attention with should be used to reach the most vulnerable and difficult segments of the population"[78].

Another 10 years passed and in 1994, the International Conference on Population and Development (ICDP) took place in Cairo.[79] The Conference adopted the Programme of Action which introduced the concepts of sexual and reproductive health and reproductive rights. The definition of reproductive rights was finally agreed for the first time globally. It defined reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." Reproductive health is than seen in a complex way as the article continues: "reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition there are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[80]

In the following paragraph, it recognised that reproductive rights "[...] embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. In the exercise of this right, they should consider the needs of their living and future children and their responsibilities towards the community."[81]

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[78] Ibid.

[79] International Conference on Population and Development. Programme of Action. Cairo, Egypt, 5-13 September 1994. Available at https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf

[80] Ibid. para 7.2

[81] Ibid at 79, para 7.3

The definition continues with the objects to pursue and states stating the importance of the state as "the promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning [...]."[82] It then illustrates the actions that any state should take: make reproductive health accessible through the primary health care system, include services and other information and the discouragement of harmful practices in their policies,[83] develop innovating programs,[84] promote a better reproductive health through a decentralization of health programmes and through the cooperation with different organisations and health care providers[85] among other initiatives.

So, even though the concept of reproduction health had appeared in research literature and in the vocabulary of health policy over the years, the unanimous definition of the concept finally appeared at the International Conference on Population and Development in Cairo in 1994.

One year later, in Beijing, the fourth World Conference on Women Action for Equality, Development and Peace adopted the Platform for Action (PfA),[86] an agenda for women's empowerment. Among its strategic objectives, it committed states parties to undertake gender-sensitive initiatives that address sexual and reproductive health issues. The Programme of Action born from the conference defines reproductive health as in ICPD Programme of Action[87] and it recognised that "[...] human rights of women include their 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. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."[88]

At the following paragraph, it further denounces that "[...] women are subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction."[89] This has a repercussion on women's health as complications related to pregnancy and childbirth and unsafe abortion are on the leading causes or mortality of women.[90] It is

[82] Ibid.
[83] Ibid. para 7.6 and 7.7
[84] Ibid. para 7.8
[85] Ibid. para 7.9
[86] Fourth World Conference on Women, Beijing Declaration and Platform for Action. Beijing, 4 to 15 September 1995. Available at http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf
[87] Ibid. para 94
[88] Ibid. para 96
[89] Fourth World Conference on Women, Beijing Declaration and Platform for Action, para 97. Beijing, 4 to 15 September 1995
[90] Ibid.

recognised that most of these deaths, health problems and injuries are preventable through improved access to adequate health-care services.[91]

Linked to this definition, the WHO defines reproductive health care as the "constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems."[92] It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

3.1 Reproductive Rights (not) in the MDGs but in the SDGs Agenda

At the turn of the century, the leader of 189 states gathered and signed the historic Millennium Declaration. Through eight goals, states committed to half extreme poverty and hunger, to promote gender equality and to reduce child mortality, by the target date of 2015.

In the original document, the Secretary General's report from which the declaration and the goals were drawn, reproductive health was not encompasses in any of the MDGs. When it is mentioned, it was always indirectly.

One year later, in August 2001, the eight MDGs drawn from the declaration, alongside with indicators and targets were published. The goals and indicators again had no explicit commitment to women's reproductive health since "if it wasn't in the declaration it couldn't be in the goals"[93] and alongside with a strong G-77's opposition in changing the labelling of "maternal health" to "reproductive health" in one of the goals during the works.

The MDGs have then reduced the broad sexual and reproductive health and rights agenda to the only domain of maternal health.[94]

Nevertheless, the UN, considered that "of the eight Goals, three - improve maternal health, reduce child mortality and combat HIV/AIDS, malaria and other diseases - are directly related to reproductive and sexual health, while four others - eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, and ensure environmental sustainability - have a close relationship with health, including reproductive health."

Despite the correlations, pressure was made until 2007, when the MDG monitoring framework was revised to include four new targets among which, a new target on Goal 5 - universal access to

[91] Ibid

[92] WHO. (n.d.). Reproductive Health. Available at http://www.wpro.who.int/topics/reproductive_health/en/

[93] Michael Doyle in an interview released on 10 November 2004. He led the working committee for the MDGs during several months of discussions and negotiations

[94] Yamin AE, Falb KL. (2012). Counting what we know: knowing what to count: sexual and reproductive rights, maternal health, and the Millennium Development Goals. Nordic Journal on Human Rights, 350–71.

reproductive health by 2015. The Goal 5.B - achieve, by 2015, universal access to reproductive health - stated that all people should have access to universal access to reproductive health and focused on contraceptive prevalence rate (5.3), adolescent birth rate (5.4), antenatal care coverage (at least one visit and at least four visits), (5.5), and unmet need for family planning (5.6).

As highlights by the briefing paper Using the Millennium Development Goals to Realize Women's Reproductive Rights', in adding the Goal 5.B, governments essentially incorporated the ICPD Programme of Action and Beijing Platform for Action into MDG 5.

By the end of 2015 some of the goals were reached through substantial progress, for example the halving of the extreme poverty rate reduced the number of people living in extreme poverty by more than half and most of countries achieved gender parity in primary education.[95] Nevertheless, not all of them succeed and, for example, the area of reproductive rights was less successful.

In July 2014, the UN General Assembly Open Working Group (OWG) proposed a document containing 17 goals to be put forward for the General Assembly's approval in September 2015. This document set the ground for the new SDGs and the global development agenda for the period 2015-2030. In 2015, countries adopted the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals. The 17 goals are interconnected between them and so the strategies and the targets to be adopted. They differ from the MDGs because their focus is not on meeting the needs of the world but it compromises governments also on a sustainable development. The concept of a sustainable development is defined as the "development that meets the needs of the present without compromising the ability of future generations to meet their own needs."[96]

SDGs are quite important for what concern sexual and reproductive health and as they include many goals and targets which can be considered as relevant for this field. They are those related to health, education and gender equality and include access to sexual and reproductive health services, comprehensive sexuality education (even though just for the Pacific area) and the ability to make decisions about one's own health.

Goal No. 3 has the aim to ensure healthy lives and promote well-being for all at all ages. Most precisely to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. The target wants to reduce by 2030, the global maternal mortality ratio, neonatal mortality and by one third premature mortality from non-communicable diseases, and end preventable deaths of new-borns and children under 5 years of age. Another target of the same goal concerns the assurance of universal access to sexual and reproductive health-care services, health

[95] UN Department of Public Information. (July 2015). MDG success springboard for new sustainable development agenda. UN report. New York.

[96] UN World Commission on Environment and Development. (1987). Our Common Future "Brundtland Report". New York, p. 71. Available at http://www.un-documents.net/our-common-future.pdf.

coverage, quality essential health-care services, and affordable essential medicines and vaccines as well as support their research and development. It includes the access for family planning, information and education and commits governments for the integration of reproductive health into national strategies and programmes

Finally, Gol 5 is aimed to the achievement of gender equality and empower all women and girls. Within its targets, to end all forms of discrimination against all women and girls everywhere in the public and private spheres and ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

4. Historical and Social Context of Obstetric Violence in South America

During the last few years, Latin America has become the spearhead of a series of laws in favour of a life free of violence for women, some of which also include obstetric violence, but the particularity of these laws is exactly that they include a wide range of types of violence within a comprehensive normative set.

A first reason for these advances in the field of the rights of women can be found in the political changes that have taken place during the last two decades and which brought to power governments with populist characteristics in several countries, in strong opposition to those neoliberal governments which characterised the region until the end of the 90s.

But analysing a little more in depth, it is possible to notice a continuous feminist struggle which started more than a century ago when organised women were succeeding in achieving more and more space in society as well as more claims.

From the mid-nineteenth century to the early twentieth century, waves of European immigrants from countries with a greater industrial tradition, arrived in Latin America, mainly to countries such as Argentina and Brazil. They carried with them many European ideas related to union organizations and workers' demands for better working conditions. These ideas were accompanied by socialist and anarchist ideas[97].

It is in this context of claims related to the social, political and economic level that women begin to claim for rights that can now be considered as universal and basic such as the access to university education, to have the possibility to manage their money, etc. For that time, women owned rights

[97] Pigna F. (2005). Los Mitos de la Historia Argentina 2. De Sán Martín a el Granero del Mundo. Buenos Aires, Argentina: Planeta, pp. 249-250.

similar to the current rights of a minor, without civil, economic or citizenship rights. For example, they could not vote, they could work only with the authorization of their husbands, and their same husbands were the administrators of their money.[98]

We can identify different stages or waves of women's struggles for their rights. In a first stage, the claims are related to equality between men and women and better working conditions. At the same time, in countries such as Argentina, there were some unsuccessful attempts to found unions or at least, to create new branches of those unions already existing with a focus on women and their participation. At the same time and in other countries, such as Colombia, women begin to mobilize for their rights. [99]

In this first stage, the claims of the right to vote or the "suffragism" can be considered as the first expression of the feminist movement, practically at the world level. This right, considered as a right of citizenship, has been a requirement even for men, who could not fully enjoy this right until the late 20th century.

Contrary to worker and union expressions of predominantly anarchist and socialist ideas, Lola Luna explains that "suffragism is the first expression of the feminist movement, and it is constructed within the liberal discourse, highlighting the contradictions of the postulates of modernity, especially the ones referring to equality, and revealing the exclusion of women in the rights of citizens [...]. The suffrage brought together several sectors of women such as feminists, socialists, conservatives, and was a central axis of the movement." Nevertheless, the author also explains that other rights were already achieved, such as success in managing their own goods, access to higher education and the occupation of public jobs.[100]

Whilst struggles for the right to vote of women began in the early 1900s, Uruguay would be a pioneer in allowing women to vote in 1927 (the first country in Latin America and the sixth in the world). Countries such as Chile, Venezuela, Panama, Brazil and Argentina would allow their feminine citizens to vote only in the 40s. In other countries like Paraguay, in 1961 women would finally achieve their right to vote (68 years after New Zealand, the first country where the female vote is imposed).[101]

In turn, at the international level, the right of women to vote was recognized only in 1948 thanks to the Universal Declaration of Human Rights. There were cases like Argentina where women could not vote, but no law prevented them from running for election. Julieta Lanteri (an Italian origin woman) is an example of one of the fighters who presented candidacy for the elections in 1919, and fought

[98] Maria Luisa Femenias, filosofa, University profesor in Mar del Plata, Argentina in E. (27 November 2017). Retrieved 5 February 2018, from https://www.youtube.com/watch?v=9Bwcemo-cjY, min 1:10. Last accessed 9 February 2018

[99] Lola Luna. (2006). Mujeres y movimientos sociales,en, Historia de las Mujeres en España y América, Ed. Cátedra, v. IV. 2006, p. 654.

[100] Ibid, p. 655.

[101] Di Liscia M. H. B. (2008). Mujeres en los movimientos sociales en Argentina. Un balance del último siglo. Cuadernos de estudios latinoamericanos No. 6, p. 148

for the universal access to the right to vote. She was also one of the women who promoted the International Feminine Congress in 1910. This International Feminine Congress defined proposals such as universal suffrage for both sexes, absolute divorce, eight hours of work for adults and six for children up to age of sixteen year, with a 36-hour continuous rest, seat for shop women, in workshops and factories, among others.[102] The congress took place in Buenos Aires, and in 1920, also in Argentina, she presented herself in an election simulation together with Alicia Moreau de Justo and Elvira Rawson, where they postulated advanced ideas for that time such as the idea of divorce, the recognition of motherhood as a function of the state, and equal rights for both legitimate and illegitimate children. [103]

At international level, the two world wars served as a turning point, since when men were in war, women had to partially occupy their place in the economy and do their jobs. This made the female gender begin to become aware of their role in society, and be able to be seen as almost equal as the role of man. [104]

In the decades of the 40s and the 50s, with the coming to power of populist governments, as in the case of Juan Domingo Perón for the Justicialist Party in Argentina, Víctor Paz Estenssoro for the Republican Nationalist Movement in Bolivia and Getúlio Vargas for the Party Brazilian Trabalhista (PTB) (Brazilian Labor Party) in Brazil, women are identified as an important section of the population. In some cases, they are incorporated in the structures of the political parties, with their own spaces of claims but without exalting too much their political demands. It is in this period that the right of the feminine vote becomes concrete in the majority of the countries, although with respect to this fact Lola Luna will say: "The major part of the populist governments gave women the right to suffrage for the interest of staying in power - women were an important section of votes and governments needed them for their legitimisation. They did not obtain the right to vote as a recognition of the political reasons that the suffrage movements fought for in Latin America since the beginning of the [twentieth] century." Although in this period women would advance in their demands, the underlying problems would not be solved and their situation and role in society would not change. [105]

Under these slogans of equality, women worldwide would progress in obtaining their rights. And in this way, the organised movements of women all around the world which had been created to obtain

[102] Pigna Felipe, Mujeres tenian que ser, 2011, p. 352

[103] Maria Herminia beatriz Di Liscia, Mujeres en los movimientos sociales en Argentina. Un balance del último siglo, en Cuadernos de estudios latinoamericanos N°6, 2008, p. 148.

[104] Padilla G., Rodríguez J. (2013). La I Guerra Mundial en la retaguardia: la mujer protagonista. Historia y Comunicación Social, vol. 18. Complutense University of Madrid, Spain, pp. 191-206

[105] Luna L. G. (2004). Los movimientos de mujeres en America Latina y la renovacion histórica. Fem-e-libros: Mexico, pp. 46-47

those rights eventually died. Nevertheless, it is important to recognise that in Latin America they had the peculiarity of lasting in time. As a matter of fact, Latin America is the place where up this day women are more organised from the social and political point of view. For example, in 1985, the closing event of the Decade of Women was held in Kenya. The ideas they argued on did not last for a long time, but the participating Argentine women returned to their country very enriched and inspired by that experience and the following year they organised the first National Encounter of Women at which nearly one thousand women took place. Up to this day it continues to be a unique experience in the world, in which more than 65,000 women and organizations from all over the country participate to discuss gender policies and women empowerment in many areas. [106]

The world context definitely changed in the 60s, a decade marked by the Cuban revolution in 1959, the Vietnam War, the French May in 1968, the reforms of the church through the Second Vatican Council, etc. Different social groups thus, began to manifest under the ideas of new and more changes. This is how feminist claims would begin to change shape, taking on strength and focusing on different areas, such as women's reproductive and sexual rights.[107]

In this context, in the 70s, a second wave or stage arouse. In the case of Latin America, in a context of authoritarian regimes (the Process of National Reorganization in Argentina, Augusto Pinochet in Chile, Alfredo Stroessner in Paraguay, Aparicio Méndez in Uruguay), feminists would be active part of the resistance. In this regard, in Chile for example, the slogan "democracy in the country and in the house" begins to emerge. [108] In this period the notion of patriarchy is strengthened by the work of Gerda Lerner and Kate Millet (among others).[109]

That is why feminists took the path of attacking against what they considered the underlying problem: the fact of living in a patriarchal society where women are subordinated and suffer daily oppression. And within this concept, they explained that the oppression and inequality suffered by women does not happen only outside the home, but also inside. On November 25, 1981, the first feminist meeting in Latin America and the Caribbean was held in Bogotá, Colombia. Today, it represents the international day of the global struggle against violence against women

[106] Encuentro Nacional de Mujeres. Historia del encuentro. Argentina. Retrieved from http://encuentrodemujeres.com.ar/historia-del-encuentro/

[107] Fernanda Gil Lozano. (2005). Feminismos en la Argentina de los 70 y los 80 presented at I Jornadas de Reflexión, Historia, Género y Política en los 70. Eje 1. Espacios de Lucha y militancia organised by Instituto Interdisciplinario de estudios de Género UBA. Buenos Aires, Argentina.

[108] Ibid at 99, p 59

[109] Ibid. pp. 25-27

This discourse of oppression of women and gender violence would become more and more present and analysed until the present. The feminist claims ceased to be democratic claims, and would become instead "survival" claims.

Since the late 1990s and the beginning of the 2000s, the political-economic problems accumulated by decades, and the economic crises that broke out in several Latin American countries, led to the emergence of a context of political change that would cause the claims of the most vulnerable and oppressed sectors of society to become widely known. With similarities and differences, governments identified with the people reappeared, such as the government of Lula in Brazil, Kirchner in Argentina, Evo Morales in Bolivia, and Chavez in Venezuela.

These governments are supported by wide sectors of the population; the same sectors which enshrined a heterogeneous list of social and political problems to be dealt with. Among them, the demands of gender equality and violence against women take force, for example Argentina, Mexico and Venezuela have been the first three countries to advance in the adoption of comprehensive laws against violence against women.

Even if in the 40s and 50s, these measures were taken to attract votes from a sector of the population, these needs of a regulation against violence against women arise in countries where, as mentioned above, there is a need to put in the agenda of the governments this need, concept well expressed within the society with slogans such as *Ni una muerta más* and *Ni una menos*. (Not one more dead and Not one less). For example, in the case of Mexico, it is estimated that 66% of women over 15 years of age suffered some kind of violence just because they were women. [110]

One of the last examples of struggles of the women's movement takes place in Argentina, where under the slogan *Ni una menos* (Not one less) women organised themselves against femicides and other forms of gender violence. This movement generated an enormous mobilization on June 3, 2015, and later other mobilisations followed, (including a women's strike) up to the present, expanding, in doing so, the slogan *Ni una menos* throughout the world. [111]

[110] Instituto Nacional de las Mujeres, I. N. (n.d.). Cero Tolerancia a la Violencia contra las Mujeres #NiUnaMenos. Retrieved from https://www.gob.mx/inmujeres/articulos/cero-tolerancia-a-la-violencia-contra-las-mujeres-niunamenos?idiom=es

[111] Ni una menos, ¿Que es Ni una menos? Retrieved from http://niunamenos.com.ar/?page_id=6

Chapter 2 Legal framework of obstetric violence: are there any rules?

Contents: 1. International legal framework; 2. At regional level; 3. At national level; 3.1 Venezuela; 3.2 México; 3.3 Argentina; 3.4 A new trend in recognising obstetric violence?

Venezuela was the first country in the world to recognise obstetric violence as a type of violence against women. More than ten years later, only few countries more (all in Latin America) have recognised it in their national law. To name a few, we can find obstetric violence in the national laws of Argentina (2009), Ecuador (2017), Paraguay (2017), and in some states of Mexico (2007-2014). In Brazil, just one state has included the definition in its federal law in 2017. Many other countries such as Chile are waiting to their national laws to be approved in their congress.

As will be studied in this chapter, many countries of Latin America have recognised obstetric violence in their national law and have adopted the same definition of it. Nevertheless, there is not any unanimous consensus on the definition of obstetric violence at international level. In medical papers concerning the issue, several different terms are used to describe the same concept which in Latin America is recognised with the term of obstetric violence. Among the most used terms, it is possible to find obstetric mistreatment, disrespect and abuse during childbirth, disrespectful care, dehumanizing care, abuse and lack of respect in gynaecology and obstetric care, unconsented care, birth rape.

This chapter is aimed at gathering a legal framework within which obstetric violence can find a legal support. The first section is dedicated to the most important international tools presenting articles which can be useful for the definition of obstetric violence as violence against women and as a lack of human rights. In the second section, the focus is on the region of Latin America, where up to now, all laws including obstetric violence have been approved. This section will provide the principal regional tools which can be helpful at the moment of an international recognition of obstetric violence. Lastly, the last section will analyse the very first law which has defined obstetric violence and the other national laws which have encompass it.

1. International legal framework

Starting from the very beginning of a possible legal framework for obstetric violence, it is necessary to put the Preamble to the Charter of the United Nations[112] first. As a matter of fact, it sets "faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women […]." Women and men then must have the same rights and be equally able to enjoy them. Three years later, the Universal Declaration of Human Rights (UDHR)[113] has been adopted. Even though, the UDHR is not legally binding, it is a great commitment for the States. At its Article 1 declares that "all human beings are born free and equal in dignity and rights" where the form "all human beings" includes both women and men considered since birth as equal and keeps on stating "...and [they] should act towards one another in a spirit of brotherhood".

At its Article 2, the declaration entitles them "to all the rights and freedoms … without distinction of any kind, such as race, colour, sex, language, religion, [...] national or social origin, property, birth or other status".

On 1966, the International Covenant on Economic, Social and Cultural Rights (ICESCR)[114] committed the states parties to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (article 12) without any kind of discrimination (article 2). To do so, States must act towards "(a) the reduction of the stillbirth-rate and of infant mortality" and "(d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness" (Article 12). On the same year, the third instrument of the International Bill of Human Right[115], the International Covenant on Civil and Political Rights (ICCPR)[116] was signed, too. This covenant states that "no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence […]" (Article 17).

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[117] adopted in 1979 by the UN General Assembly, is often described as an international bill of rights for women. In its Article 1 the expression "discrimination against women" denotes "all distinction,

[112] Charter of The United Nations and Statute of The International Court of Justice. San Francisco, 1945. Available at https://treaties.un.org/doc/publication/ctc/uncharter.pdf

[113] UN General Assembly, Universal Declaration of Human Rights, Paris, December 10, 1948. Available at http://www.un.org/en/universal-declaration-human-rights/

[114] UN General Assembly, International Covenant on Economic, Social and Cultural Rights. 16 December 1966. Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

[115] The International Bill of Human Rights includes the UDHR, the ICESCR, the ICCPR, the Optional Protocol to the ICCPR, and the second Optional Protocol to the ICCPR

[116] UN General Assembly, International Covenant on Civil and Political Rights. 16 December 1966. Available at http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx

[117] UN General Assembly, Convention on the Elimination of All Forms of Discrimination against, 18 September 1979, Article 1. Available at http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#

exclusion, restriction based on sex which results in a reduction of the fullest enjoyment of the same rights for women and men."

As defined in general recommendation number 19[118], discrimination includes "gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately". The general recommendation specifies what gender-based violence can include: "acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty."

In article 2 of the Convention, states parties agree to "embody the principle of the equality of men and women in their national constitutions, to adopt sanctions and establish legal protection of the rights of women." Furthermore, in 2(d), States agree to ensure that "public authorities and institutions will act in conformity with the obligations originated from the convention and to pursue the elimination of discrimination against women by any person, organization or enterprise." Therefore, States Parties agree on eradicate any type of violence against women from national institution and performed by people and enterprise under which it is possible to include public health facilities and health staff.

The convention does not focus on the maternal aspect of women's life however it sets an important landmark at its article 5 where states parties agree about the "importance of ensuring that family education includes a proper understanding of maternity as a social function."

The convention then deals with the issue, specifically with one of the roots of gender-based violence committing state parties to ensure "equal rights in the field of education in specific through the access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning." [119]

In its part III, Article 12, States Parties shall take all appropriate measures to "eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" and above all, to "ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

The Article 14 invites States Parties to **"**take into account the particular problems faced by rural women and [to] take all appropriate measures to ensure the application of the provisions" to them and "in particular, to ensure the right (b) to have access to adequate health care facilities, including information, counselling and services in family planning".

[118]Committee on the Elimination of Discrimination against Women, General Recommendation No. 19 Violence Against Women, 1992. Available at http://www.ohchr.org/EN/HRBodies/CEDAW/Pages/Recommendations.aspx

[119] UN, Convention on the Elimination of All Forms of Discrimination against Women, Article 10(h). 1979

Eventually, in article 16 the convention reiterates the right of the parents to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

Talking about racial discrimination, the International Convention on the Elimination of All Forms of Racial Discrimination[120] refers to it as "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life" (article 1). States parties agree on the prohibition and elimination of all form of racial discrimination in article 5 and to guarantee the enjoyment of a series of rights, among which, we find the right to "public health, medical care, social security and social services" (Article 5(iv)).

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [121] describes the term "torture" as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as [...] punishing him for an act he or a third person has committed or is suspected of having committed."

The right to be free from torture is recalled in the article 7 of the International Covenant on Civil and Political Rights [122] which adds that "no one shall be subjected without his free consent to medical or scientific experimentation." At its previous article (article 6), the covenant sets one of the most important rights in international law namely the right to life setting that "every human being has it and no one shall be arbitrarily deprived of his life."

Also children have their rights recognised at international level. For example, according to the Convention on the Rights of the Child [123], children are entitled to the "enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" (Article 24). For its part, States shall purse the reduction of "(a) infant and child mortality, (d) ensure appropriate pre-natal and post-natal health care for mothers as well as the (b) provision of necessary medical assistance and health care." Also, the Convention on the Rights of the Child reaffirms the agreement of states parties against torture or other cruel, inhuman or degrading treatment or punishment in its article 37. No child shall be subjected to any kind of treatment like these.

[120] UN General Assembly, International Convention on the Elimination of All Forms of Racial Discrimination 21 December 1965. Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx

[121] UN General Assembly, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. 10 December 1984. Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx

[122] UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966.Available at http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx

[123] UN General Assembly, Convention on the Rights of the Child. 20 November 1989. Available at http://www.ohchr.org/en/professionalinterest/pages/crc.aspx

In 2007, 160 states signed the Convention on the Rights of Persons with Disabilities (CRPD)[124] to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their dignity"[125]. Article 6 of the convention focuses on women with disabilities which are subject to multiple discrimination, and in this regard recognises the need to ensure "the full and equal enjoyment by them of all human rights and fundamental freedoms" of course "free from torture or cruel, inhuman or degrading treatment or punishment, protecting the integrity of the person" (article 17), "respecting their privacy" (article 22) and, "respecting their decisions in all matters relating the founding of a family and to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education, and the means necessary to enable them to exercise these rights" (article 23). As underlined in aside (c): "persons with disabilities, including children, retain their fertility on an equal basis with others." In article 25, it is recognised the right to the enjoyment of the "highest attainable standard of health without discrimination on the basis of disability [...] including in the area of sexual and reproductive health and population-based public health programmes."

2. At Regional Level

The Inter-American system for the protection of human rights has created, since its foundation, an important body of charters and conventions on human rights.

The American Declaration on the Rights and Duties of Man[126] adopted by the Ninth International Conference of American States, the chart which found the Organisation of American States is technically not a legally binding document but it is an important source of strong commitments by the States Parties. The Declaration was issued some months before the Universal Declaration of Human Rights, being so the first international human rights tool. It states, at its Article 1 that "every human being has the right to life, liberty [...]" and in its Article 2 that "all persons […] have the rights and duties established in the Declaration, without distinction as to race, sex, language, creed or any other factor." At its Article 6, states the right to "establish a family, the basic element of society, and to receive protection therefore" and at its Article 7, states that "all women, during pregnancy and the nursing period, and all children have the right to special protection, care and aid." So, besides the rights of life, liberty and personal security and the right to equality before law which are embedded

[124] UN, Convention on the Rights of Persons with Disabilities. 30 March 2007. Available at http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

[125] Ibid Article 1

[126] Ninth International Conference of American States, Article 1, American Declaration on the Rights and Duties of Man, Bogotá, Colombia, 1948. Available at http://www.oas.org/en/iachr/mandate/Basics/declaration.asp

in the first articles of all declarations about human rights, the declaration mentions also the importance of the right to a family and to protection thereof stressing the importance of the right to protection for mothers and children and the need for pregnant women for special protection, care and aid.

The American Convention on Human Rights (American Convention), known also as the Pact of San José,[127] defines in its first Article the freedom of every human being to fully exercise rights and freedoms listed in the Convention. Nevertheless, it also recognised that the rights of each person are "limited by the rights of others, by the security of the general welfare, in a democratic society" (Article 32.2). There have been some misunderstandings at the moment of the interpretation of Article 4 about the right to life which states that "every person has the right to have his life respected [...] from the moment of conception." The substantive "conception" means the process in which the egg in a woman is fertilized and she becomes pregnant.[128] According to this article then, fetus are entitled of human rights, too. At its Article 5 about the Right to Humane Treatment, every person has the right to have their "physical, mental, and moral integrity respected and no one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment".

As reported by the Protocol of San Salvador[129] in its Article 10, "everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being." States Parties must regard health as a public good and adopt measures to ensure it.

The American convention to protect women's right is the Convention for the Prevention, Punishment and Eradication of Violence Against Women shortly known as the Convention of Belém do Pará. [130] It is the only international treaty that specifically address violence against women.[131] Article 1 of the convention defines violence against women as "any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere." This can occur in (article 2) in both the public and private spheres such as the domestic context, in the community and can also be perpetrated by the State.

Instead, the American convention for the protection of the right of people with disabilities is the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with

[127] OAS, American Convention on Human Rights "Pact of San José", San José, Costa Rica, November 22, 1969. Available at http://www.oas.org/dil/treaties_B-32_American_Convention_on_Human_Rights.pdf

[128] "Conception". Collins Dictionary. [online]. Accessed 18 January 2018. Available at: https://www.collinsdictionary.com/dictionary/english/conception

[129] OAS, Additional Protocol to The American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. San Salvador, El Salvador, 17 November 1988

[130] OAS, Convention for the Prevention, Punishment and Eradication of Violence Against Women, Belém, Brazil, 9 June 1994

[131] Centre for Reproductive Rights. (October 2002). Reproductive Rights in the Inter-American System for the Promotion and Protection of Human Rights, p. 8. Available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_rr_interamerican.pdf

Disabilities.[132] The convention seeks the elimination of all types of discriminations against people with disabilities (Article 2).

Year 2013 saw the adoption of two Inter-American Conventions: The Inter-American Convention against Racism, Racial Discrimination, and Related Intolerance [133] and the Inter-American Convention against All Forms of Discrimination and Intolerance.[134] The first convention has been signed and ratified by a few countries whilst the second one has still not been ratified by any State, yet.

The two Inter-American Convention define at their first Articles the term "racial discrimination" and "racism" and recognise the intersectionality of many factors of discrimination[135] (Article 1(3)).

3.At national level

At this point, it is necessary to study the national laws which recognised and typified obstetric violence in their country with particular focus on the first 3 countries which recognised it as a crime.

In the last decade, many countries of Latin America have adopted Integrated Laws on Violence Against Women which list the causes of such violence and try to define all types of violence against women and the measures to prevent it: Argentina (2009), Bolivia (2013), Colombia (2008), Costa Rica (2009), Ecuador (2017), El Salvador (2012), Guatemala (2008), México (2013), Nicaragua (2012), Paraguay (2016), Perú (2015), Venezuela (2007) and last but not the least, in December 2017 also Uruguay.

Among all the countries of Latin America which adopted Integrated Law on Violence Against Women, only six of them, Venezuela, Argentina, Mexico, Ecuador, Paraguay, and Uruguay include the term obstetric violence.

An important point that is essential to underline is the fact that many countries have recognised obstetric violence in their national law but very few of them have recognised it as a crime therefore there is no sanction for health personnel who mistreat women during pregnancy, labour and after partum cares in the states where obstetric violence is just recognised but not criminalised.

Why all Integrated Law on Violence Against Women have been adopted in Latin America? Latin American countries have a big process ongoing for the eradication of violence against women.

[132] OAS, Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities, Guatemala, 6 August 1999

[133] OAS, Inter-American Convention against Racism, Racial Discrimination, and Related Intolerance, La Antigua, Guatemala, 5 June 2013

[134] OAS, Inter-American Convention against All Forms of Discrimination and Intolerance, La Antigua, Guatemala, 5 June 2013

[135] The concept of intersectionality will be discussed later in Chapter 3, section 3

According to the study Femicide: A Global Problem,[136] "more than half of the 25 countries with high and very high femicide rates (at least 3 femicides per 100,000 female population) are in the Americas: 4 in the Caribbean, 4 in Central America, and 6 in South America" for a total of 14 of 25 countries in the region. The high rate of feminicide is strictly linked to a social tolerance towards the violence against women and children.

3.1 Venezuela

The first law to take into consideration and to analyse is the Venezuelan law. The Organic Law on the Right of Women to a Life Free of Violence entered into force on March 19, 2007 and was later amended in 2014. The law was created to pursue the eradication of values, beliefs and practices which determined gender inequality and to guarantee, in behalf of the State, the enjoyment and exercise of women's human rights. This view was embedded in the idea of socialism of the 21st century[137], a mix of caudillism, populism and militarisation of public institution[138] as well as memories from the past such as the figure of Simon Bolivar[139] president Chávez wanted for Venezuela.

Considered as one of the most advanced legal instruments on the subject that exist in Latin America and the Caribbean by the Venezuelan ambassador to the United Nations[140], it is an organic law that at its Article 15, lists and typifies 21 forms of violence against women. At aside 13 obstetric violence is described as "the appropriation of women's body and reproductive process by health personnel, which is expressed by a dehumanising treatment, an abuse of medicalisation and pathologisation of natural processes, resulting in a loss of autonomy and ability to decide freely about their body and sexuality, negatively impacting their quality of life."[141] This is the first definition of obstetric violence in the jurisprudence and it is the starting point for following laws and further studies on the issue.

The law then recognises a series of procedures which result in obstetric violence performed by health

[136] Matthias Nowak. (February 2012). Femicide. A Global Problem. Small Arms Survey Research Notes No. 14. Geneva, Switzerland. Available at http://www.smallarmssurvey.org/fileadmin/docs/H-Research_Notes/SAS-Research-Note-14.pdf

[137] The Socialism of the 21st century is a type of socialism which takes inspiration on Marx's vision of society and economy but with a focus on the changes happened in the last century. It was pursued by the former president of Venezuela Hugo Chávez (president of Venezuela from 1999 until his death in 2013).

[138] Castronovo V. (2007). Piazza e caserme. I dilemmi dell'America Latina dal Novecento a oggi. Bari: Editori Laterza, p. 287

[139] Gardini G.L. (2012). Latin America in the 21st Century. Nations, Regionalism, Globalization. London: Zed Books, p. 38

[140] Statement by ambassador Jorge Valero Permanent Representative of the Bolivarian Republic of Venezuela to the United Nations, Item 28: Advancement of Women Third Committee. New York, October 11, 2010. Available at http://www.un.org/womenwatch/daw/documents/ga65/Venezuela.pdf

[141] Gaceta Oficial No. 40.548 de la República Bolivariana de Venezuela, Ley Orgánica Sobre el Derecho de Las Mujeres a una Vida Libre de Violencia. Caracas, Venezuela, April 23, 2007. Available at http://www.derechos.org.ve/pw/wp-content/uploads/11.-Ley-Org%C3%A1nica-sobre-el-Derecho-de-las-Mujeres-a-una-Vida-Libre-de-Violencia.pdf

personnel.[142] These procedures are:

1. Failure to give a prompt and effective response to obstetric emergencies.
2. Forcing the woman to give birth in a supine position and with her legs raised, in case of possibility for a vertical delivery.
3. Preventing the child's early attachment to their mother in absence of a justified medical cause, denying the possibility of immediate breastfeeding after birth.
4. Altering the natural process of low risk childbirth through the use of techniques of acceleration, without obtaining voluntary, express and informed consent of the woman.
5. Practicing delivery by caesarean section in presence of the conditions for a natural delivery, without obtaining the voluntary, express and informed consent of the woman.

In such cases, the court will fine the perpetrator two hundred and fifty (250 U.T.) to five hundred tax units (500 U.T.).[143]

3.2 Mexico

In 2007, the Senate of the United States of Mexico approved the General Law of Access of Women to a Life Free of Violence but it does not still contemplate obstetric violence. Instead, at federal level, 20 states out of the total states of Mexico (31 federal states plus the Federal District of Mexico) define obstetric violence in their local laws on Access to a Life Free of Violence. These states are:

[142] Ley Orgánica Sobre el Derecho de Las Mujeres a una Vida Libre de Violencia, Article 51, Venezuela, 2007

[143] Tax units or Unidades Tributarias are a measure which is regularly updated according to the inflation of Venezuela, used in Venezuelan tax laws and regulations. At 2017, the amount of one U.T. was of 300 Venezuelan Bolivares according to the last update of February 24, 2017 of the Gaceta Oficial Extraordinaria N° 6.287. The Venezuelan Bolivar lost 96% of its value in 2017 and its change is currently at 84,000 bolivars to buy one US dollar.

Aguascaliente,[144] Baja California,[145] Campeche,[146] Chiapas,[147] Chihuahua,[148] Coahuila,[149] Colima,[150] Durango,[151] Estado de México, Guanajuato,[152] Guerrero,[153] Hidalgo,[154] Morelos,[155] Puebla,[156] Querétaro,[157] Quintana Roo,[158] San Luís Potosí,[159] Tamaulipas,[160] Tlaxcala,[161] and Veracruz,[162]

[144] State Law on Access to a Life Free from Violence for the State of Aguascaliente. Article 8, VI. August 22, 2016. Available at http://www.ags.gob.mx/transparencia/docs/art55/fracc%201/estatal/LEY%20DE%20ACCESO%20DE%20LAS%20MUJERES%20A%20UNA%20VIDA%20LIBRE%20DE%20VIOLENCIA%20PARA%20EL%20ESTADO%20DE%20AGUASCALIENTES.pdf

[145] State Law on Access to a Life Free from Violence for the State of Baja California. Article 6, VI. Available at http://transparencia.pjbc.gob.mx/documentos/pdfs/leyes/LeyAccesoMujeresVidaLibreViolenciaBC.pdf

[146] State Law on Access to a Life Free from Violence for the State of Campeche. Article 5, VI. Available at http://legislacion.congresocam.gob.mx/images/legislacion/leyes/pdf/Ley_de%20_Acceso_Mujeres_Vida_Libre_de_Violencia.pdf

[147] State Law on Access to a Life Free from Violence for the State of Chiapas. Article 6, VII. September 14, 2011. Available at http://www.cndh.org.mx/sites/all/doc/programas/mujer/5_LegislacionNacionalInternacional/Legislacion/Estatal/Chiapas/B/Ley%20de%20Acceso%20a%20una%20Vida%20Libre%20de%20Violencia%20para%20las%20Mujeres.pdf

[148] State Law on Access to a Life Free from Violence for the State of Chihuahua. Article 5, VI. July 16, 2014. Available at http://www.cndh.org.mx/sites/all/doc/programas/mujer/5_LegislacionNacionalInternacional/Legislacion/Estatal/Chihuahua/B/Ley%20estatal%20del%20derecho%20de%20las%20mujeres%20a%20una%20vida%20libre%20de%20violencia.pdf

[149] State Law on Access to a Life Free from Violence for the State of Coahuila, Article 8 bis.

[150] State Law on Access to a Life Free from Violence for the State of Colima. Article 30 bis. May 16, 2015. Available at http://cdhcolima.org.mx/wp-content/uploads/2017/01/Ley-de-Acceso-de-las-Mujeres-a-una-Vida-Libre-de-Violencia.pdf

[151] State Law on Access to a Life Free from Violence for the State of Durango. Article 6, III. Available at http://congresodurango.gob.mx/Archivos/legislacion/LEY%20DE%20LAS%20MUJERES%20PARA%20UNA%20VIDA%20SIN%20VIOLENCIA.pdfhttp://congresodurango.gob.mx/Archivos/legislacion/LEY%20DE%20LAS%20MUJERES%20PARA%20UNA%20VIDA%20SIN%20VIOLENCIA.pdf

[152] State Law on Access to a Life Free from Violence for the State of Guanajuato. Article 5, VIII. December 3, 2013. Available at http://imug.guanajuato.gob.mx/wp-content/uploads/2017/06/Ley_de_Acceso_de_las_Mujeres_a_una_Vida_Libre_de_Violencia_P.O._29_DIC_2015.pdf

[153] State Law on Access to a Life Free from Violence for the State of Guerrero. Article 10, VII. Available at http://i.guerrero.gob.mx/uploads/2016/04/Ley-n%C3%BAmero-553-de-Acceso-de-las-Mujeres-a-una-Vida-Libre-de-Violencia-del-estado-Libre-y-Soberano-de-Guerrero.-P.O.-08-02-2008.-%C3%9Altima-reforma-26-11-2013.pdf

[154] State Law on Access to a Life Free from Violence for the State of Hidalgo. Article 5, VI. Article 45 XII. March 30, 2015. Available at http://www.congreso-hidalgo.gob.mx/biblioteca_legislativa/Leyes/12Ley%20de%20Acceso%20de%20las%20Mujeres%20a%20una%20Vida%20Libre%20de%20Violencia.pdf

[155] State Law on Access to a Life Free from Violence for the State of Morelos. Article 20, VI. Available at http://marcojuridico.morelos.gob.mx/archivos/leyes/pdf/LMUJERVVEM.pdf

[156] State Law on Access to a Life Free from Violence for the State of Puebla. Article 10, VII. Available at http://www.ordenjuridico.gob.mx/Documentos/Estatal/Puebla/wo96587.pdf

[157] State Law on Access to a Life Free from Violence for the State of Querétaro. Article 20, quarter. Available at http://legislaturaqueretaro.gob.mx/app/uploads/2016/01/LEY055.pdf

[158] State Law on Access to a Life Free from Violence for the State of Quintana Roo. Article 5, VII. December 9, 2014. Available at http://documentos.congresoqroo.gob.mx/leyes/L122-XV-20170704-75.pdf

[159] State Law on Access to a Life Free from Violence for the State of San Luís Potosí. Article 3.VII. June 30, 2015. Available at http://congresosanluis.gob.mx/sites/default/files/unpload/legislacion/leyes/2017/11/Ley_de_Acceso_de_las_Mujeres_a_una_Vida_Libre_de_Violencia_10_Octubre_2017.pdf?platform=hootsuite

[160] State Law on Access to a Life Free from Violence for the State of Tamaulipas. Article 3, f. March 24, 2015. Available at http://po.tamaulipas.gob.mx/wp-content/uploads/2017/04/Ley_Violencia_Mujeres.pdf

[161] State Law on Access to a Life Free from Violence for the State of Tlaxcala. Article 6, VI. March 4, 2016

[162] State Law on Access to a Life Free from Violence for the State of Veracruz. Article 7, VI. February 28, 2008. Available at http://www.veracruz.gob.mx/medioambiente/download/LEY-235-DE-ACCESO-A-LAS-MUJERES-UNA-VIDA-LIBRE-DE-VIOLENCIA.pdf

They all define obstetric violence in their state law but at 2017, only five penal codes consider it as a crime and provide sanctions for who carries out these practices.[163] These states are Chiapas[164], Estado de México[165], Guerrero[166], Veracruz[167] and Quintana Roo[168].

For example, obstetric violence is typified since 2008 in the state of Veracruz, the first Mexican state to regulate it. At its Article 7(VI) obstetric violence is described exactly as it is in the Venezuelan law. Law of the other states have adopted more or less the same structure and definition. In the Penal code of Veracruz, obstetric violence is sanctioned at Article 363 whit a period of 6 months up to 3 years of prison and a fine equivalent of up to 300 days of salary. Moreover, if the perpetrator is a public employee, the penalty includes the removal from office of the professional up to a maximum period of two years. The penalties in the other four Mexican penal codes are similar.

3.3 Argentina

For what concern Argentina, it is important to first remind the law 25.929 on Humanised Birth[169] because it was the basis on which the subsequent law on obstetric violence would refer. The Law on Humanised Birth states that all pregnant women have the right to be informed, to be treated with respect, to be considered as healthy and finally recognises the right to a natural birth, in accordance with the biological and psychological needs and time of the woman and the child, avoiding any invasive practices and the administration of medicaments not justified by the health of the woman or of the baby.

Following the National Law Nº 25.929 on Humanised birth, Argentina approved in 2009 the Law 26.485 for the Integral Protection of Women for Preventing, Sanctioning, and Eradicating Violence Against Women.[170] The law at its article 6(e) defines obstetric violence as "the treatment exercised by health personnel on women's body and their reproductive processes, expressed in a dehumanized treatment, an abuse of medicalization and the pathologisation of natural processes, in accordance with the rights established in the previous law of Humanised Birth 25.929."

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[163] Grupo de Información en Reproducción Elegida. Obstetric Violence. A Human Rights Approach. 2015, p. 54

[164] Código Penal del Estado de Chiapas, Article 183 Ter and 183 Quater as modified in December 2014. Available at http://www.congresochiapas.gob.mx/new/Info-Parlamentaria/LEY_0012.pdf?v=Nw==

[165] Código Penal del Estado de México, Article 276. Available at http://legislacion.edomex.gob.mx/sites/legislacion.edomex.gob.mx/files/files/pdf/cod/vig/codvig006.pdf

[166] Código Penal del Estado de Guerrero, Article 202 and 203 as modified in August 2014

[167] Código Penal del Estado de Veracruz de Ignacio de la Llave as modified in 2010. Available at http://www.legisver.gob.mx/leyes/LeyesPDF/PENAL200217.pdf

[168] Código Penal del Estado de Quintana Roo, Article 112 bis. Available at http://documentos.congresoqroo.gob.mx/codigos/C6-XV-20171227-132.pdf

[169] Ley nacional N.º 25.929 de Parto Humanizado. September 17, 2004. Available at https://www.unicef.org/argentina/spanish/ley_de_parto_humanizado.pdf

[170] Ley nacional N.º 26.485 - Ley de protección integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales, 1 April 2009. Available at https://www.oas.org/dil/esp/Ley_de_Proteccion_Integral_de_Mujeres_Argentina.pdf

One year later, a decree[171] specifies that it is considered as dehumanized treatment any "cruel, dishonourable, disqualifying, humiliating treatment or threatening exercised by health personnel in the context of pregnancy care, delivery and postpartum, either to the woman or to the new-born, as well as in the care of complications of natural or induced abortions, whether punishable or not." Another important step is made by the recognition of health personnel to all those working in a health facility: professionals (doctors, nurses, social workers, psychologists, obstetricians, etc.) and those who take care of the hospital services and administration. In addition to that, the decree underlines the right, for the women who attend the aforementioned institutions, to refuse the implementation of the practices proposed by the health personnel. Lastly, the decree invites the institutions in the field of public health, private and social security to expose graphically, visibly and in clear language and accessible to all users, the rights embedded in the law.

3.4 A new trend in recognising obstetric violence?

Last year saw three Latin American countries including obstetric violence in their law. Even though it is still too early to notice any impact in health services, it is of great importance to recognise the existence of a trend, for what concern Latin America, in a growing recognition of obstetric violence within the national legal framework.

In the State of Santa Catarina in Brazil with the State Law 17.097[172], obstetric violence is considered as any act committed by the doctor, the hospital staff, a family member or companion who, verbally or physically offends pregnant women, in labour or even in the puerperium.

Some important and new details are added: In Article 2, among the other perpetrators, obstetric violence can be performed by a family member or a companion, [173] too. It is the first time in a law on obstetric violence, that relatives are nominated as possible to offend the puerpera with mocking, offences, aggressive behaviour, and any other kind of mistreatment. It is an important step, in a nation that has the 5th highest index of femicides in the world[174] and where 33.2% of the total amount of women assassinated in Brazil were committed by a relative and one in three assassinated by their partner or ex-partner.[175]

[171] Decreto 1011/10 - Ley De Protección Integral A Las Mujeres - Reglamentación de la Ley 26.485 de protección integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales. 19 July 2010

[172] Law on the implementation of measures of information and protection pregnancy and obstetric violence in the State of Santa Catarina. 19 January 2017. Available at http://www.tjsp.jus.br/Download/Pdf/Comesp/Leis/Lei_17097_2017.pdf

[173] Lei estadual 17.097. Article 2. 2017, Brazil

[174] ONU (April 2016). Taxa de feminicídios no Brazil é quinta maior do mundo; diretrizes nacionais buscam solução. Available at https://nacoesunidas.org/onu-feminicidio-Brazil-quinto-maior-mundo-diretrizes-nacionais-buscam-solucao/

[175] Waiselfisz J.J. (2015). Mapa da Violência 2015: Homicídio de mulheres no Brazil. Brazilia, Brazil, p. 73. Retrieved from http://www.mapadaviolencia.org.br/pdf2015/MapaViolencia_2015_mulheres.pdf

In Article 3, the law lists all conduits which can be considered for the purposes of the law, as a verbal or physical offense. Point XI bans procedures which make women subject to painful, unnecessary or humiliating procedures and, among the examples (pubic hair shaving, etc…), it is also mentioned the touch examination by more than one professional. And further on, at point XVII of the same article, the law makes express ban to submit the woman and / or baby to procedures exclusively to train students. No law had regulated the medical training on patient as obstetric violence before. Another detail which demonstrates the progress of the jurisprudence in the field.

As pointed out by Arnaud Peral at forum for the creation of the Organic law for the prevention of the violence against women in Quito, the UN was suggesting Ecuador to create a law to eradicate violence in all its forms.[176] Eventually, last November the Assembly of Ecuador approved the Law to Eradicate Violence Against Women.[177] For what concerns the topic, Ecuador legislates on gynaeco-obstetric violence. As a matter of fact, apart from a description of what pregnant women can suffered, the law considers as victims also "not pregnant women [who] can suffer violence during their gynaecologist or obstetric attention when it is realised through invasive practices or psychological or physical mistreatment." An innovative and more comprehensive view of obstetric violence then, which will help Ecuador to low its rate of violence against women and women death (for example unsafe abortion is the third cause of mortality for women in Ecuador).[178]

Also Paraguay recognises obstetric violence in its Law for the protection of women against violence its article 7(j) and recognises the violation of the human rights of women.[179]

Uruguay has been the last state of Latin America to approve a Law[180] comprehensive of obstetric violence (Article 6(h)) among the different types of violence, in December 2017.

[176] Pese a políticas para erradicar violencia contra las mujeres, América Latina y el Caribe es la región más violenta: PNUD – ONU Mujeres. (n.d.). Retrieved 31 January 2018, from http://www.un.org.ec/?p=12754

[177] Ley Orgánica Integral para la Prevención y Erradicación de la Violencia de Género contra las Mujeres. Article 11, f. November 26, 2017. Available at http://americalatinagenera.org/newsite/index.php/es/centro-de-recursos?title=Ley+org%C3%A1nica+sobre+el+Derecho+de+las+Mujeres+a+una+Vida+Libre+de+Violencia&search=enviado&keyword=&autor=&pais=&anio=&open=cri1900

[178] Ecuador: Congress Boosts Women's Protection Against Violence. 29 December 29 2017 https://www.telesurtv.net/english/news/Ecuadors-Congress-Approves-Bill-on-Gender-Violence-20171129-0043.html

[179] Ley 5777 de Protección Integral a las Mujeres, contra toda forma de violencia, December 2016. Available at http://www.sipi.siteal.iipe.unesco.org/sites/default/files/sipi_normativa/ley_5777_de_2016_proteccion_integral_a_las_mujeres_contra_toda_forma_de_violencia_-paraguay.pdf

[180] Ley Integral para Garantizar a las Mujeres una Vida Libre de Violencia Basada en Género. Article 6(h). Available at https://parlamento.gub.uy/documentosyleyes/leyes?Ly_Nro=&Ly_fechaDePromulgacion%5Bmin%5D%5Bdate%5D=01-12-2017&Ly_fechaDePromulgacion%5Bmax%5D%5Bdate%5D=31-12-2017&Ltemas=violencia+&tipoBusqueda=T&Searchtext=

CHAPTER 3. Obstetric violence as a violation of human rights

Contents: 1. Which human rights are violated with obstetric violence?; the Right to Life, Liberty, and Security; the Right to Health; the Right to Privacy; the Right to Information; the Right to Equality and to be Free from Discrimination; Discrimination Against Women; as a woman from the rural area; the Right to Not be Subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment; the Right to Enjoy Scientific Progress and its Application; 2. The right to maternal care; 2.1 What does maternal care include?; 2.2 When is it important? 3. Is it possible to talk about institutional violence?; 3.1 Current status of the right; 3.2 Discrimination within dedication; 4. Issues of intersectionality; 4.1 Intersectionality in the access to health services; 4.2 Situation in Latin America; 5. Is there any international framework?.

1. Which human rights are violated with obstetric violence?

Obstetric violence can violate a wide range of human rights both of pregnant women and new-borns. This chapter will attempt to outline the main rights that obstetric violence can violate and according to which international and regional tools. The list also includes the Universal Declaration of Human Rights, the Program for Action of Cairo and the Beijing Platform for Action which are not technically legally binding documents for States Parties. Nevertheless, they play an important role enshrining the core of the human rights and acting as a strong commitment by the States Parties.

In this chapter, there are listed some of the most important human rights which are violated when obstetric violence is performed. Among others, it is important to focus on the right to health which will be discussed more in depth, and its characteristics underlined as well as on the right to be free from discrimination will split into the discrimination as a woman and as indigenous or from a rural area person. A section in particular is dedicated to maternal care, what it includes and when it is needed. The following section concerns the topic of institutional violence and, within the same section, the norms that should rule the actions of health personnel. Lastly, the concept of intersectionality will be addressed and related to the access to health care in Latin America.

The list of rights cannot be exhaustive due to the complexity and fragmentation of the experience of obstetric violence that can considerably vary, however, the principal rights which are violated by obstetric violence are:

The Right to Life, Liberty, and Security

Probably, the first and most important right at all is the right to Life. In fact, it is also recognised as the supreme right, it admits no derogation and must not be interpreted narrowly.[181]
This fundamental right is expressed, together with the right to liberty and security, in the Universal Declaration of Human Rights (Article 3). The International Covenant on Civil and Political Rights divided them in two different articles: an exclusive article for the right of life, in doing so it highlights the importance of this right and adds that it shall be protected by law (Articles 6.1) and another article for the right to liberty and security (Article 9.1). Programme of Action of Cairo (Principle 1) gathers together the three rights as in the Universal Declaration of Human Rights, as well as does the Convention on the Rights of Persons with Disabilities (Article 10).

At regional level, the right to life can be found in Article 4 of the American Convention on Human Rights, a right to be protected from the moment of conception. The recognition of the right to life since the very first moment will be later argued in jurisprudence.[182]

The Right to Health

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."[183] And indeed, the right to health is perhaps the most important rights that will be analysed in the study.
In 1946, the WHO defined the term health in its Constitution as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[184] It recognised also the enjoyment of the highest standard of health as one of the fundamental rights of every human being.[185]
Two years later, it is recognised in the Article 25(1) of the Universal Declaration on Human Rights, closely related to other factors: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services." In the following aside, it commits states to guarantee special care and assistance for motherhood and childhood.

[181] Human Rights Committee, General comment No. 6: Article 6 (Right to life). 1982, para 1
[182] In the case Artavia Murillo et al. ("In Vitro Fertilization") v. Costa Rica of November 2012, the ICHR confirmed that it is not admissible to give the status of person to the embryo (para 233). Insofar, stated that the protection of the right to life is not absolute, but is gradual and incremental according to its development, [and] it does not constitute an absolute duty unconditional, but implies understanding the origin of exceptions to the general rule" (para 264). Full case is available at http://www.corteidh.or.cr/docs/casos/articulos/seriec_257_esp.pdf
[183] Dr. Martin Luther King, Jr, 25 March 1966, The Second National Convention of the Medical Committee for Human Rights, Chicago, Illinois
[184] WHO. (22 July 1946). Preamble to the Constitution of the World Health Organization. New York.
[185] Ibid.

In the Covenant on Economic, Social, and Cultural Rights, it is recognised the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Article 12(1)) and, as in the Universal Declaration of Human Right, a makes a special reference to mothers for the special protection that should be accorded to her and her new-born during a reasonable period before and after childbirth (10(2)).

The Committee on Economic, Social, and Cultural Rights clarifies that the right does not only include the right to be healthy and to have access to health care but it contains both freedoms and entitlements: "[f]reedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture and non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[186] It includes also the right to the enjoyment of a variety of facilities, goods, services and conditions[187]. As clear, the right to health is a complex right as it includes also different aspects which are called the underlying determinants of health. [188] These underlying determinants of health consist in the access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.[189] Furthermore, the right to health, according to the same General Recommendation, must contain four interrelated and essential elements,[190] which are:

1. Availability: services must be available throughout the jurisdiction of the State in a sufficient quantity.
2. Accessibility: health facilities, goods and services must be accessible under four different variables:
    - Non-discrimination: services must be accessible to everyone within the population without discrimination and with a special attention to the most vulnerable or marginalized sections of the population.
    - Physically accessible: health services and information must be accessible within safe physical reach. It means that all the population, including the most vulnerable or marginalized sections of the population have the possibility to reach the services, also in rural areas.

[186] Committee on Economic, Social and Cultural Rights. General Comment No. 14: The Right to the Highest Attainable Standard of Health. 11 August 2000, para 8
[187] Ibid. para. 9
[188] Ibid. para. 4
[189] Ibid. para. 11
[190] Ibid. para. 12

- Affordability: services must be accessible from the economic point of view also for the poorest sections of the population.
- Access to information: it consists in the right to seek for information and have access to it but also the right to express information and ideas.

3. Acceptability: all services and personnel must accept and respect medical ethics and the different cultures of the patients.
4. Quality: facilities, goods and services must be scientifically and medically appropriate and of good quality. This variable includes the presence of skilled and trained health personnel, the presence of no expired drugs and equipment, water and sanitation.

In sum, the right to health is a comprehensive right which does include many aspects. In fact, the right to health is not enjoyable just from the material point of view but it enshrines many other factors and that is the reason why states have not only the duty to make available medical goods and services but they must be sure that everyone has the possibility to benefit from them.

Other international instruments which regulate the right to health are the Convention on the Elimination of All Forms of Discrimination against Women, the international bill against discrimination against women, which recognises, at Article 12 the need for the elimination of the discrimination against women "in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning." At the following aside, it recognises the guarantee of appropriate services "in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation without any discrimination" (art.12.2).

As underlined by the Committee on Economic, Social and Cultural Rights and the Committee on the Convention on Elimination of Discrimination against Women (CEDAW) women's right to health includes their sexual and reproductive health.

In addition to what already said about the right to health, everyone should be assured the access to health services without any kind of racial discrimination as in the Convention on Racial Discrimination (Article 5(e)(iv)).

Other international tools which recognise the right to health are the Convention on the Rights of the Child (Article 24), and the Vienna Declaration and Programme of Action which recalled it on 1993 underlining the need to access to the highest standards of health, both physically and mentally (para 41), and the importance of the elimination of violence against women through national actions and international cooperation in many fields, among which, in the field of safe maternity and health care (para 18).

Under this right, it is necessary to cite that the ICPD Programme of Action, among its principles, it assures the universal access to health care services including family planning and for the first time,

sexual health. (principle 8). In fact, it also gives the first definition, globally accepted, of reproductive health and what it includes (para 7(2)): the possibility to have a satisfying and safe sex life and the capability and freedom to reproduce. One year later, the right to the enjoyment of the highest attainable standard of physical and mental health for women is retook by the Beijing Platform for Action. As it explained, this right is vital to the life and wellbeing of women (para 89) and for this reason it must be "secured throughout the whole life cycle as for men" (para 92). The same section states the right to health involves "women's emotional, social and physical well-being and not only the physical wellbeing." Furthermore, it states that this right is determined by "the social, political and economic context of their lives, as well as by biology" (para 89). Notwithstanding this, it also denounces that health and well-being elude the majority of women (para 89)

At regional level, everyone has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, (Article XI of American Declaration of the Rights and Duties of Man), and very important, this is especially true for all women, during pregnancy and the nursing period, and all children who have the right to special protection, care and aid (Article VII). Furthermore, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 embeds it at Article 10. In this article States Parties commit themselves to recognize health as a public good and, in particularly, to adopt some measures to ensure that primary health care is available to all in the community referring in particular to the highest risk groups and the poorest and thus most vulnerable sectors of the population.

The Right to Privacy

The right to privacy means that no interference to one's personal decisions is allowed and includes the limits people can interfere in one person's issues (Universal Declaration of human Rights at its Article 12). Many rights are correlated with the right to privacy for example, linked with the reproductive sphere, it entails the right to make autonomous decisions about issues concerning their reproductive rights. In 1966, the right to privacy is explained as the right a person has not to "be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation" (Article 17 of the International Covenant on Civil and Political Rights).

Beijing denounced that often women are frequently not treated with respect, and they are not guaranteed privacy and confidentiality (para 93). This datum indicates the need for health workers to

be trained in order to be gender-sensitive and not interfere with the user's privacy and confidentiality (106(f)).

In Beijing the right to privacy is always related to confidentiality. Confidentiality is the right that protect the information given by a patient to their physician. The right must be kept confident which means that it must not be divulged or, in case of need, it must be divulged only with the permission of the patient. Also the ICPD Programme of Action kept related privacy and confidentiality and agreed on the need to develop them, for example in relation to family planning (para 7.23(c)).

The right to privacy in the health field concerns for example the free decision about personal medical issues, for example, it includes whether to accept or refuse a particular type of medical procedure for family planning or the right to receive promptly the results from a medical exam as well as the right to be provided with trustful data. In fact, in the case of the provision of false data in order to obtain a consent, the right to privacy is undermined because it lacks the bases on which a conscious and autonomous decision can be formulated.

At regional level, the right to privacy is considered in the American Convention on human rights (Article 11)

The right to information

The right to information is especially important in the field of reproductive rights as it is at the basis of conscious choose about one person's rights.[191]

The Universal Declaration of Human Rights, at its Article 19, recognises the right to information as part of the right to freedom of opinion and expression or better as part of the fact to "seek, receive and impart information and ideas through any media and regardless of frontiers."

The International Covenant on Civil and Politic Rights included it in the right to freedom of expression, too. In Article 19(2), it is specified that it must be "regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice."

It is possible to find the right to information in the Convention on the Elimination of Discrimination against Women, at Article 10(h). This article states that women should have access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning. This must be available as well as for rural women (Article14 (b)).

Cairo reiterates the need for the States Parties to guarantee the right to information in many fields; one of these, for example, is in the context of reproductive health care, which, according to Principle

[191] Inter-American Commission on Human Rights. (22 November 2011). Acceso a la Información en Materia Reproductiva Desde una Perspectiva de Derechos Humanos, p. 1, para 3. Retrieved from http://www.cidh.oas.org/pdf%20files/mujeresaccesoinformacionmateriareproductiva.pdf

7.6, should include the right to information "on human sexuality, reproductive health and responsible parenthood." The Program underlines also the importance of the right to information in order to make "responsible decision […] concerning health, sexual and reproductive behaviour, family life and patterns of production and consumption" (Actions 11.11).

Paragraph 95 of the Beijing Declaration and Platform for Action condemns the fact that "reproductive health eludes many of the world's people" due to many factors among which, it includes "inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information". Few paragraphs later, the Declaration denounces that women do not always receive full information about the options and services available. It is for this reason that strategic objective C.1 includes the right to information in the contest of health care as well as the redesign of the information provided by health and medical personnel in order to be gender-sensitive towards patients.

The Committee on Economic, Social and Cultural Rights develops a close connection between the right to information in the field of health and reproductive health "because of the special importance of this issue in relation to health."[192]

One of the essential elements of the right to health is in fact the accessibility to information (para 12(b)) which consists in "the right to seek, receive and impart information and ideas concerning health issues." The same article, however, precises that "accessibility of information should not impair the right to have personal health data treated with confidentiality."[193] Confidentiality means the medical duty to maintain professional secrecy about information given by their patient.[194] It is a decisive interest of sexual and reproductive health.[195]According to Rebecca Cook, the characteristics that a confidential information entails are:

- the duty of health service providers to protect information from patient against unauthorized disclosures;
- the right of patients to know the information that providers of health services have over them;
- the duty of health service providers to make sure that the patients who authorize the disclosure of confidential information to others related to their health, do so in the exercise of a free and informed decision. [196]

[192] Committee on Economic, Social and Cultural Rights. General Comment No. 14: The Right to the Highest Attainable Standard of Health. 11 August 2000

[193] Ibid at para. 11.

[194] Cook R., Dickens B., Fathalla M. (2003). Salud Reproductiva y Derechos Humanos, Integración de la medicina, la ética y el derecho, p. 162. Bogotá, Colombia. Retrieved from https://www.law.utoronto.ca/utfl_file/count/documents/reprohealth/rh_hr_spanish.pdf

[195] Ibid

[196] Ibid.

The health information patients should have access to, includes:

- Their current reproductive health condition in relation to all aspects of possible diseases and other issue.
- A reasonable access to medical, social, and other types of sources that can satisfy the patient's reproductive conditions and intentions. That includes predictable success rates, side effects, and the risks of each option
- The implications for the patient's sexual and reproductive health and for the general health and lifestyle of the patient in case the patient refuses the options
- The provider's recommendations and a truthful medical justification.[197]

From the regional point of view, the instruments that regulate the right to information are the Article 13 of the American Convention on Human Rights. The Office of the Special Rapporteur for Freedom of Expression, in the Declaration of Principles on Freedom of Expression of the Interamerican Commission on Human Rights underlines the importance of the article 13 beforementioned that must be enjoyed "without any discrimination for reasons of race, colour, sex, language, religion, political or other opinions, national or social origin, economic status, birth or any other social condition" (Principle 2).[198] Furthermore, it established that "every person has the right to access to information about himself or herself or his/her assets expeditiously and not onerously, whether it be contained in databases or public or private registries, […]"[199]

The Interamerican Court on Human Rights considers that the right to access information is also affected by the denial of access to medical history information. Consequently, the American States must guarantee to people the full access to the information contained in their medical records, under penalty of sanction, present in database, public or private records. [200]

The Court has also pointed out that the lack of reproductive information operates as a barrier to access to maternal health services because it prevents women from making free and informed decisions about their health, and as a consequence the lack of adequate behaviours for the prevention and promotion of their health and that of their children.[201]

[197] Ibid p. 149

[198] OAS, Inter-American Commission on Human Rights, Inter-American Declaration of Principles on Freedom of Expression, October 2000

[199] Ibid at Principle 3

[200] Inter-American Commission on Human Rights. (22 November 2011). Acceso a la Información en Materia Reproductiva Desde una Perspectiva de Derechos Humanos, para 106. Retrieved from http://www.cidh.oas.org/pdf%20files/mujeresaccesoinformacionmateriareproductiva.pdf

[201] CIDH, Acceso a Servicios de Salud Materna desde una Perspectiva de Derechos Humanos, 7 de junio de 2010, para. 33.

The Right to Equality and to be Free from Discrimination

Non-discrimination and equality are fundamental human rights principles and critical components of the right to health. Everyone should enjoy all rights and freedoms without discrimination of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Universal Declaration, Article 2). The International Covenant on Economic, Social and Cultural Rights (art. 2 (2)), the Civil and Political Rights Covenant (Article 2.1) and the Convention on the Rights of the Child (art. 2 (1)) add more characteristics. Furthermore, States must act also without discrimination on national or social origin, property, birth or other status[202], race, colour, descent, or national or ethnic origin[203]as well as on the basis of disability.[204] According to the Committee on Economic, Social and Cultural Rights, "other status" may include health status (e.g., HIV/AIDS) or sexual orientation. States have an obligation to prohibit and eliminate discrimination on all grounds and ensure equality to all in relation to access to health care and the underlying determinants of health. The International Convention on the Elimination of All Forms of Racial Discrimination (art. 5) also stresses the fact that States must prohibit and eliminate racial discrimination and guarantee the right of everyone to public health and medical care.
The right to be free from discrimination also recognised that forced sterilisation, or women's inability to access reproductive healthcare services because of women's race, ethnicity or national origin are to be considered as a violation of the treaty.[205]

At regional level, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador" regulates the obligation of non-discrimination at its Article 3. The convention Belem do Pará on the Prevention, Punishment, and Eradication of Violence against Women states that the right of every woman to be free from violence includes, among others, the right of women to be free from all forms of discrimination (Article 6(a)) as well as the right of women to be valued and educated free of stereotyped patterns of behaviour and social and cultural practices based on concepts of inferiority or subordination (Article 6(b)).
In 2013, two interesting conventions have been signed by some states in Latin America: the Inter-American Convention Against Racism, Racial Discrimination, and Related Forms of Intolerance and

[202] The right of no discrimination can be found in Article 1 of the Convention on the Elimination of all Forms of Discrimination Against Women; Articles 2 of the International Covenant on Civil and Political Rights; Article 2(2) of International Covenant on Economic, Social and Cultural Rights
[203] UN General Assembly, International Convention on the Elimination of all Forms of Racial Discrimination, Article 1. 21 December 1965
[204] UN General Assembly, Convention on the Rights of Persons with Disabilities, Article 2. 13 December 2006
[205] Center for Reproductive Rights. (August 2008) Abortion and Human Rights Government Duties to Ease Restrictions and Ensure Access to Safe Services, p. 12

the Inter-American Convention Against All Forms of Discrimination and Intolerance but they have not been ratified by many states yet.

Discrimination against women

Within the human rights context, the practice of obstetric violence could be considered as a form of discrimination against women since women experienced an exclusion or a restriction based on sex at the moment to access to particular health care service, for example when a pregnant woman in need looks for health services and there is no availability close by or when she is refused to be visited. It applies also to women who have already suffered from mistreatments and prefer other techniques to satisfy their needs. In this way, many woman's human rights are violated. Article 1 of the Convention on the Elimination of all Forms of Discrimination against Women gives us the definition of discrimination against women as any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women of human rights and fundamental. In fact, some aspects of obstetric violence discriminate women by not allowing them to fully enjoy their human rights and fundamental freedoms and more specifically, some reproductive rights. In this way, their rights are nullified since they cannot enjoy them anymore.

According to Article 12 an equal access to health care services should be ensured to both men and women, according to their needs including the access to services related to family planning. To what concern pregnant women, emphasis is placed on the access to services related to pregnancy, confinement and the post-natal period. Women should have also the guarantee to have access to free services where necessary, as well as adequate nutrition during pregnancy and lactation.

In connection with the social perception of the role of women in the society which often attribute the role of mothers to all women, states committed to review and modify their patterns of conduct to eradicate prejudices that foster stereotypes about the inferiority or superiority of one sex with respect to the other (Article 5a) in policies and practices (ICPD Programme of Action, para 5.5) and from modern and customary practices (Beijing, para 224). The convention then calls for a modification of stereotypes and mentalities which can result in patriarchal attitudes towards women in order to eliminate possible sources of discrimination towards women. The same stereotyped view which can be found in many health facilities as women as objects.

Finally, the CEDAW requires states parties to undertake a series of measures in order to prohibit all discrimination against women, including by applying sanctions where appropriate (Article 2b).

The Vienna Declaration (para 8) considers the eradication of all forms of discrimination on the ground of sex as a priority objective of the international community as does the ICPD (para 4.4) including reproductive and sexual health in women's human rights.
Beijing recognises the many barriers women must face to fully enjoy equality and advancement (para 46). For this reason, the document commits States to pursue the promotion and protection of the full and equal enjoyment by women and men of all human rights and fundamental freedoms without distinction of any kind (para232)

In the inter-American system, the 1948 Inter-American convention on the Granting of Civil Rights to Women stated that women have all the same civil rights that men enjoy.

Discrimination as a woman from rural areas and as indigenous people

Vienna Declaration gives great importance to the promotion and protection of the human rights of persons belonging to groups which have been rendered vulnerable, including migrant workers, the elimination of all forms of discrimination against them, and the strengthening and more effective implementation of existing human rights instruments (para 24.) States have a commitment to help them also in the field of health, among others.
The CEDAW devotes the Article 14 for the elimination of discrimination against women in rural areas ensuring them, in Article 2, the access to adequate health care facilities and information and services in family planning among other rights. It barely cites Indigenous women.[206] For this reason, five years later, Indigenous activists managed to set an important milestone and organised the International Indigenous Women's Forum (Foro International de Mujeres Indígenas (FIMI)) in New York at the Beijing +5 review in 2000 and eventually they adopted a declaration in which they underline the rights of Indigenous women.
Instead, it is possible to find a racial point of view in the convention against racial discrimination which stated that all forms of discrimination should be eliminated and the right to public health, medical care and social security and services should be guaranteed to everyone.
In 2008, the Declaration on the Rights of Indigenous People[207] was approved. It is the first international tool recognising the rights of Indigenous people. Its Article 2 recognises the equality of indigenous people compared to all other peoples and the right to be free from discrimination based on their indigenous origin or identity.

[206] UN Fourth World Conference on Women. Platform for Action. September 1995. Section 32
[207] UN General Assembly, Declaration on the Rights of Indigenous People, 13 September 2007

An important article is the Article 24 which enshrines the right to the indigenous people to their traditional medicines and to maintain their health practices as well as the right to access, without any discrimination, to all social and health services for the enjoyment of the highest attainable standard of physical and mental health.

The Right to Not be Subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment

First included in the Article 5 of the Universal Declaration, Article 7 of the Civil and Political Rights Covenant, and later defined by the Torture Convention[208], torture means "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for […] any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity". A right that must be protected under all circumstances (the Vienna PfA para 56). The same Convention on Torture prohibits torture in Article 2 and other cruel, inhuman or degrading treatment and punishment in Article 16. In the last decades, the term "torture" has been increasingly recognised and used in contexts other than for example, interrogations of detainees in the field of health care.[209] There are four elements that classify an act as torture: "firstly, an act inflicting severe pain or suffering, whether physical or mental; secondly, the element of intent; thirdly, the specific purpose; and lastly, the involvement of a State official, at least by acquiescence."[210]
Paragraph 24 of a Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment[211] states that "indeed, the State's obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres." Therefore, the responsibility of the state is recognized also through the action of its employees also in areas of public service like health facilities.

At regional level, torture is prohibited in the Article 5 of the Pact of San José[212] but the most important document concerning the issue is the Inter-American Convention to Prevent and Punish

[208] UN General Assembly, Convention against Torture, Article 1(1), 10 December 1984
[209] UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez. 1 February 2013, para 15 and para 16. Available at http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf
[210] UN General Assembly, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, 9 February 2010, para 43
[211] Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez. 1 February 2013
[212] OAS. American Convention on Human Rights "Pact of San José". San José, Costa Rica, 22 November 1969

Torture. In its Article 2, torture is also recognised as the use of methods upon a person intended to obliterate the personality of the victim or to diminish his/her physical or mental capacities, even if they do not cause physical pain or mental anguish. Article 3 identifies who can practice torture and thus shall be held guilty of this crime: (a.) "a public servant or employee who acting in that capacity orders, instigates or induces the use of torture, or who directly commits it or who, being able to prevent it, fails to do so" and (b.) "a person who at the instigation of a public servant or employee mentioned in subparagraph (a) orders, instigates or induces the use of torture, directly commits it or is an accomplice thereto."

The Right to Enjoy Scientific Progress and its application

In the medic field of reproductive, new scientific and technological progress is an important factor which can always be applied. For example, it is through new scientific discoveries that it is possible to reduce stillbirths, mortality and morbidity or to have access to new contraceptions or other family planning services. For this reason, the Right to Enjoy to Scientific Progress and its application has an important role and that is why it should be possible to everyone to have access "to the benefits of scientific progress. Scientific advances in the field of medical research and medicine, for example, should be within (financial) reach for all."[213]

At international level it is embedded in the Universal Declaration of Human Rights (Article 27) as the right to enjoy the scientific advancement and as the right its benefits and as scientific progress and its applications in the International Covenant on Economic, Social, and Cultural Rights, Article 15 (1) (b) and Vienna Declaration. Nevertheless, nobody should be subjected to medical or scientific experimentation without their free consent (Civil and Political Rights Covenant, Article 7).

Notwithstanding, the World Conference on Human Rights in Vienna notes that certain advances, notably in the biomedical and life sciences as well as in information technology, may have also a negative aspect and carries some potentially adverse. For this reason, it calls for an international cooperation to ensure that human rights and dignity are fully respected in the light of the respect to the dignity and the rights of the human being."[214]

The Report of the Special Rapporteur on the field of cultural rights[215] recognizes the importance of the right to enjoy to scientific progress and its application as a prerequisite for the realization of a number of other human rights[216]. In paragraph 32 for example reaffirms the importance of the

[213] UNESCO. (2009). The Right to Enjoy the Benefits of Scientific Progress and its Applications. Paris, France, p. 5
[214] World Conference on Human Rights. Vienna Declaration and Programme of Action, Article 11. Vienna, 25 June 1993
[215] Human Right Council, Report of the Special Rapporteur in the field of cultural rights, Farida Shaheed on the right to enjoy the benefits of scientific progress and its applications, 14 May 2012
[216] Ibid para. 23

enjoyment of the right to allow people to make informed decisions after having reflected on both the positive aspects and side effects concerning the use, for example, of a new scientific discovery. Nevertheless, it reminds again the importance of the participation of the recipient during the decision.

At the regional level, it is cited for first time in the Charter of the Organization of American States (Article 38) as un invitation from the states to exchange among themselves the benefits of science and technology. The American Declaration of the Rights and Duties of Man (Article XIII) declares the universality of the "right […] to participate in the benefits that result from intellectual progress, especially scientific discoveries" Rights recognised also by the Additional Protocol to the to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights at the Article 14 (1) (b).

5. The right to maternal care. An overview

As declared in 2017 by Tedros Adhanom Ghebreyesus, the Director-General of the WHO, "Universal health coverage is the centre of gravity of global health, but women, [children and adolescent] health is the centre of gravity of universal health coverage."[217]
Indeed, maternal care has been a central issue for a long time. For example, it is considered so important that was also part of the eight Millennium Development Goals (MDGs). As a matter of fact, MDG No. 5 aimed at improving maternal health reducing by three quarters the maternal mortality ratio.

The WHO defines maternal health as the health of women during pregnancy, childbirth and the postpartum period. The Organisation also recognises that while motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death.[218]
The right for women to be protected during pregnancy, delivery and postpartum is internationally recognised in many different international tools. The Universal Declaration of Human Rights recognises the special care and assistance that must be provided during motherhood and childhood.[219]
Article 12 of the CEDAW compromises States Parties to ensure appropriate services for pregnancy, confinement and the post-natal period.[220] Finally, the Convention on the Rights of the Child recognises the right of a child to the highest attainable health care. The International Covenant on

[217] Every Woman Every Child. (July 2017). Progress in Partnership: Launch of the 2017 Progress Report on Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health
[218] WHO, maternal health. Available at http://www.who.int/maternal-health/en/
[219] UN General Assembly, Universal Declaration of Human Rights, Article 25(2). 10 December 1948
[220] UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against, Article 12, 1979

Economic, Social and Cultural Rights encompass it, too and the General Comment No. 14[221] clarifies that the Article 12(2)(a) of the Covenant on the right to maternal, child and reproductive health "may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information." The right to maternal health is then a comprehensive right which enshrines a great variety of services which must be available for both the mum and the baby.

2.1 What does maternal care include?

According to the standards for improving quality of maternal and new-born care in health facilities,[222] maternal care encompasses many factors. The standards have been developed by the WHO as a method to reach "quality care throughout pregnancy, childbirth and the postnatal period" for all mums and new-borns. The 31 quality statements grouped under eight standards of quality which should be reached, are aimed to assess and monitor resources, the performance of health personnel and health facilities and are an important instrument for a continuous improvement of health services.

Standard 1 is about the care women and new-borns should receive during labour, childbirth and the early postnatal period. It includes the need of a complete, accurate, standardized medical record for every woman and baby complete of all relevant data on their health status. It states that babies should receive a birth certificate, too.

The second standard concerns the recording of both the mum and the baby conditions and the third one establishes the instruction to report immediately in case of negative conditions of both the mum and the new-born which may arise at any time and cannot be properly dealt with the scarce available resources available in the health facility. This permits to take immediate and effective measures to prevent the health situation from worsening.

The following three standards regulate the personal relationship between health personnel and patients. The communication towards women must be effective and based on the provision of clear and accurate information about their health conditions and the risks of procedures they may have to undergo and must be done in the full respect and dignity of the women with special attention to the emotional support the woman needs. Women should always be involved in issues concerning her pregnancy and labour. A special statement to point out is the No. 5.2 which states that no woman or

[221] General Comment No. 14 on the article 12 of the International Covenant on Economic, Social and Cultural Rights. 11 August 2000

[222] WHO. (2016). Standards for improving quality of maternal and new-born care in health facilities. Geneva, Switzerland. Available at http://apps.who.int/iris/bitstream/10665/249155/1/9789241511216-eng.pdf?ua=1

new-born should be subjected to mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.

The last two points refer to the quality of the service disposed by the health care regarding both the staff who must be skilled and motivated and the facilities which must have an appropriate environment and do not lack of basic instruments, supplies and equipment. The standards underline the importance of a satisfying work environment for health staff in order to prevent possible low outcomes due to dissatisfaction and frustration.

All these standards are important because they give an idea of what a mum should expect and receive when she is pregnant and need for maternal care.

Besides, imbedded in the right to maternal care, there are the four variabilities as for the right to health. In fact, to be effective, a woman seeking maternal care must be able to:

- Have access to maternal care without no regard to factors as the colour of her as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,[223] among other characteristics.
- Be able to find maternal care services and facilities within safe physical reach, that is the ability of women to find them within the territory in an adequate number.
- Be able to access maternal care from the economic point of view. That should be possible even for women who are part of the most social vulnerable sections of the population
- Have information about facilities, goods and services alongside with the possibility to receive and compart information and idea about her health issues.

2.2 When is it important?

The right to maternal care has indeed some other characteristics. Among these, there is the right to receive the right care at the right time:

During pregnancy and before the partum, "good care […] is important for the health of the mother and the development of the unborn baby. Pregnancy is a crucial time to promote healthy behaviours and parenting skills."[224] The care received before the delivery is called antenatal care (ANC) and as underlined by the WHO, not only does it asset the general health state of the mum and the foetus but also it is the first opportunity for pregnant woman to link her and her family with the formal health system. This is an important pace for pregnant women in many countries as a positive first contact has many more possibility to result in an assisted birth, which means less risks for both the mum and

[223] UN General Assembly, Universal Declaration of Human Rights, 10 December 1948, Article 2

[224] Joy Lawn and Kate Kerber. (2006). Opportunities for Africa's Newborns. Practical data, policy and programmatic support for newborn care in Africa. Eds. PMNCH, Cape Town, p. 52. Retrieved from http://www.who.int/pmnch/media/publications/oanfullreport.pdf

the new-born, and also contributes to establish a relationship based on trust that will have a positive outcome through the life cycle of the woman.[225]On the contrary, in the event that the pregnant woman experienced an insufficient level of care, this would probably "breaks a critical link in the continuum of care."[226] In this case, it is less probably that a woman who has a negative first experience, comes back for a second visit, even in the case of a risk for both her and her baby.

During these first examinations, health care personnel have the possibility to detect immediately the chance of a difficult outcome due to illness or other pathologies and have also the opportunity to provide all information about a healthy style in such a delicate period as a pregnancy, as well as further information.[227]

The WHO recommend at least four medical examinations in case of a health woman (the number can raise up to eight in case of diagnosis of complicacies or need to further studies). That is to help women preparing the labour and understand some warning signals during pregnancy and, in case of necessity, to administer nutrients and injections, to test HIV and other diseases to prevent the transmission of these to the baby [228] and to prevent morbidity, stillbirth, and other complications related to pregnancy and possible mortality. Despite the fact that 90% of women in Latin America and Caribbean receive at least four prenatal examinations, there are great inequality among the women who are visited. In some countries such as Colombia, Haiti, Nicaragua, Panamá and Suriname, the average of four prenatal examinations among illiterate women is three times lower compared to the rest of women[229] and 30 percentage points is the difference between the number of the richest women and the poorest women who made at least four prenatal visits in Haiti and Nicaragua.[230]

In the rest of the region, the average difference between poor and rich women affording prenatal examinations lies between 20 and 23 percentage points.[231]

The difference becomes even more remarkable when it concerns the ethnicity and the color of the skin of women who access maternal services. From the same report, Afro descendant women in Brazil and indigenous women in Guatemala are less likely to access to examinations and prenatal care besides experiencing a lower quality in the care they receive.[232]

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[225] Ibid.
[226] Ibid.
[227] WHO. (7 November 2016). Pregnant women must be able to access the right care at the right time, says WHO. Geneva, Switzerland. Retrieved from http://www.who.int/mediacentre/news/releases/2016/antenatal-care-guidelines/en/
[228] UNICEF. (2016). Informe sobre Equidad en Salud 2016, p. 12. Retrieved from http://www.apromiserenewedamericas.org/wp-content/uploads/2016/12/Informe-sobre-Equidad-en-Salud-2016.pdf
[229] "Salud Materna." Todas Las Mujeres Todos Los Niños, 16 Jan. 2017. Retrieved 29 January 2018 at www.everywomaneverychild-lac.org/areas-de-trabajo/salud-materna/.
[230] Ibid. at 228
[231] Ibid. p. 9
[232] Ibid.

During labour time, women must be able to receive skilled attention care and help. It requires health personnel to assess woman's and foetus's health condition asking, checking and recording signals to assure the best outcome possible. Due to the great variability of symptoms and diagnoses and possible complications, it is really important to have the presence of a high trained and skilled personnel.[233] Maternal care includes taking care of women and new-borns also soon after the delivery, for example with a complete assessment before discharge that should be performed. In case of a small or sick baby, they will be cared in the same health facility to prevent neonatal death or long-term health problems and lifelong disabilities and in case of need, kept in specialised neonatal units to be closely monitored.[234]

In Latin America and the Caribbean, there are huge inequality during delivery among women from different economic backgrounds. In Haiti, the worst case of Latin America, only 10% of the poorest women, have access to maternal attention.[235] A low level of education affects women as well as the geographical provenience, too. It has been noticed that women less literate as well as women from rural areas have less accessibility to maternal care compared to their literate and urban equals.[236] Another characteristic which has a great influence on the quality of care is the cultural provenance: Indigenous women and Afro-American women have less probability to have access to it. As data shown, only 30% of Indigenous women from Guatemala and 57% of Indigenous women from Nicaragua had quality attention during their delivery.[237] Nevertheless, governments are doing their best to improve the access to quality maternal care since in the last years there have been some important improvements in the region.[238]

Lastly, the postnatal care which is the care addressed to the mother and the new-born after labour is equally important. Maybe the most important part of the post-natal period is the so called "golden" or "sacred hour". It is the first skin to skin contact between the mum and the new-born and according to different studies, it conveys many positive outcomes for both the mum and the baby. The first hour is also the most critic hour in a child life as it entails a lot of drastic changes and dangers.[239] Placing the child skin to skin on the bare mum breast has shown to have positive benefits on the child. This type of contact also helps the natural breastfeeding with all the benefits that this can bring. Children

[233] For more information: WHO. (2015). Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice Third Edition, section D, 2015. Retrieved from http://www.who.int/maternal_child_adolescent/documents/imca-essential-practice-guide/en/

[234] WHO. (February 2017). 10 Ways to improve the quality of care in health facilities. Retrieved from http://www.who.int/features/2017/quality-care-facilities/en/

[235] Ibid at 228, p. 11

[236] Ibid p. 9

[237] Ibid p. 57

[238] Ibid.

[239] UNICEF. (2015). Determinantes sociales y ambientales para el desarrollo de los niños y niñas desde el período del embarazo hasta los 5 años. Bases Para Un Diálogo Deliberativo, p. 44.

who had the possibility of experience the golden hour have showed significative differences on the relationship with their mothers, compared to those who spent their first hour divided. For this reason, the WHO[240] [241] supports and encourages an early and uninterrupted skin-to-skin contact as soon as possible after birth.

Throughout the region, there is a high degree of inequality. For example, countries like Bolivia, Haiti and Honduras have the lowest rate of postpartum care. The datum worsens when referring to people from rural areas and illiterate women.[242] Nevertheless, countries like Colombia have less difference (the percentage of new-borns receiving postnatal cares and new-borns who did not is only 7%).[243]

Lastly, it is necessary to highlight a datum from Panamá which shows the difference between Afro-American and Indigenous people, very often mistreat at the same level. Whilst in Panamá, 100% of Afro-American new-borns received postpartum care, only 70% of their Indigenous equals experienced the same.[244]

Even though it is endorsed in many international tools, maternal care is still far from being universally accessible and many parts of the population have poor if no access to maternal care. Regarding the causes of the difficult access to maternal care, a study from the Georgetown Law's Human Rights Institute and O'Neill Institute for National and Global Health Law[245] found out that it mostly relies on three factors[246]. These factors are:

The low degree of empowerment of women in certain countries or areas, the physical insistence of adequate facilities and other services dedicated to maternal care, and a lack in the recognition of the dignity and respect of women.

- Low empowerment in social and economic issues refers to the situations in which women are considered as second-class citizens and have no possibility to make autonomous decision about issues of their reproductive sphere. This includes the fact that many adolescents become pregnant and have to carry their pregnancy to term.

[240] At this regard, WHO. (2017). Protecting, promoting and supporting breastfeeding in facilities providing maternity and new-born services. Geneva, Switzerland.

[241] WHO. (2017). Protecting, promoting and supporting breastfeeding in facilities providing maternity and new-born services. Geneva, Switzerland. Available at http://www.who.int/elena/titles/full_recommendations/breastfeeding-support/en/

[242] Ibid.

[243] Ibid.

[244] Ibid.

[245] Human Rights Institute and O'Neill Institute for National and Global Health Law. (2012). Maternal Health and Human Rights. National and Global Perspectives. Retrieved from https://www.law.georgetown.edu/academics/centers-institutes/human-rights-institute/events/upload/2012-Maternal-Health-and-Human-Rights-Outcome-Document.pdf

[246] Ibid pp. 8-11

For example, in many areas of Latin America, there is a high rate of adolescent pregnancy. In the period from 2005 to 2015, an average of 70 of every 1,000 girls aged between 15 and 19 was pregnant whit higher percentages regarding women from rural areas.[247]

Early pregnancies led to undermine the social and cultural life of a women with less chance to pursue an empowerment, as well as to an early decline of the physical health of women.

- For what concern the physical presence of facilities and services dedicated to maternal care, that is related to the low quantity of hospitals or health care centres which sometimes are available only in cities and in many cases, they are not close to rural or poorest areas. This problem involves also the lack of infrastructure to reach them when they are available (roads, public means of transport, long distances from the main concentration of poor and at risk pregnant women) and the lack of skilled and trained health professionals and frequent shortage of medicaments, equipment and other supplies, too.

The quality of the physical facilities is an important issue and, as underlined by the WHO, even if "the rate of skilled care during childbirth has increased from 58% in 1990 to 73% in 2013, mostly due to increases in facility-based births, giving birth in a health facility does not equate with a safe birth."[248] As a matter of fact, even if there are health facilities accessible to all women, it does not mean they are of good quality for women who seek maternal care.

The WHO defines quality care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes." In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable and people-centred."[249]

To be safe, care must put at minimum the risks and harm of the patients as well as reduce to the minimum possible medical errors. To be effective, care provided must rely on scientific and technological knowledge as well as on guidelines. To be timely, care must be always provided in a short term, reducing unnecessary delays. This component is inversely proportional to the efficacy of care provided. In fact, at the increasing time required to take care of a person corresponds a decrease in the effectiveness of the action.

Efficiency of the care means that health care must be provided in the most effective way possible, maximizing resources and avoiding waste, this is especially important for those countries where there are few resources available and the are many people to take care of. The last two components are somehow linked. The fact that the care is equitable means that the services offered by health facilities

[247] UN Department of Economic and Social Affairs, Population Division. (2017). World Population Prospects. The 2017 Revision. New York, custom data acquired via website.

[248] WHO. (n.d.). What is the Quality of Care Network? Retrieved from http://www.who.int/maternal_child_adolescent/topics/quality-of-care/network/en/

[249] WHO. (2006). Quality of Care A process for making strategic choices in health systems. Geneva, Switzerland, p. 9-10

must not change in number and quality with respect to personal characteristics of the patient such as sex, race, ethnicity, geographical origin or socioeconomic status. Health care must be provided to all users on the same level of quality and with the same characteristics. And finally, care must be people-oriented, that is that health personnel must keep in mind preferences and aspirations of their patients, with particular reference to the culture from which they come from.

- Finally, the third barrier to the access to maternal care is the ack of recognition of the dignity and respect of women. Many times, women who enter ward maternity experience discrimination or mistreatment in their care by health personnel. In fact, they are often dealt with sufficiently, their opinion and explanations are not taken into account and there is often a breach in the confidentiality in the relationship doctor-patient. Often, information provided by the staff is partial or partly erroneous. In general, verbal mistreatments and physical abuse in health care facilities have a long-term outcome. Apart from severely violate the dignity and respect of women, these behaviours can make women less tempted to seek health care in the future, with serious repercussions on the general health of the woman.

Many times, the abuses and mistreatments are due to the difficult working conditions of health workers who are forced to work in health facilities which are not appropriate (see for example chapter 1, section 1). In some cases, there is a brain drain of doctors, looking for another job in other areas or in large cities, further aggravating the situation in the most difficult areas.[250]

3. Is it possible to talk about institutional violence?

The most well-known definition of institutional, or structural violence, has been given by the sociologist Johan Galtung in 1969[251]. He first referred to violence as "the cause of the difference between the potential and the actual, between what could have been and what is. Violence is that which increases the distance between the potential and the actual, and that which impedes the decrease of this distance."[252] He clarified the concept giving an example of how it can apply to real life: it was quite normal if a person died from tuberculosis in the eighteenth century because of the lack of care to prevent the disease. But if a person dies from tuberculosis today, that can be considered as violence since there are many treatments available that allow people to survive and recover from the disease.

Galtung also analysed the problem of the author of violence to give the complete definition of structural violence. He wondered whether or not it is possible to talk about violence when nobody is

[250] Ibid. at 21
[251] Galtung J. (1969). Violence, Peace, and Peace. Journal of Peace Research, Vol. 6, No. 3, pp. 167-191.
[252] Ibid p. 170

committing direct violence. In case there is no actor that commits the violence, the violence is then structural.[253] Even though, there is no person then that directly harms others, the violence "is built into the structure and shows up as unequal power and consequently as unequal life chances". In fact, resources and the power to decide how to allocate them are unevenly distributed and influence the outcomes in life of the people who receive (or not) them.

In our field of study therefore, the example of violence can be translated into the difficulty to have access to health facilities and receive effective and adequate pre- and postpartum care among other services. Nowadays, they should be considered as almost universal but in some cases, like in the cases of obstetric violence, services are not equally distributed among the population. This fact damages some categories of women who are mistreated and do not always receive this kind of care during their pregnancy and delivery because they belong to some specific categories, namely the most vulnerable of society.

It may take different, forms, for example, it can be embedded in national laws or in patterns of conduct that harm rights or through socially acceptable behavior.

As it is possible to notice from various articles cited in the previous sections, the role of the state is central to the full enjoyment of rights with particular reference to health and reproductive rights. In fact, the state not only has the task of providing adequate health services, goods, tools, equipments but has also to provide information on the various techniques of family planning, procedures that affect pregnancy and the time of delivery and on series of information that will be useful to the mother during the post-partum period. The state must also ensure that doctors, nurses, and all medical and non-medical personnel with whom a pregnant woman or in the puerperio may come into contact, are respectful of her physical and psychological integrity as well as of her dignity and privacy, among other factors. As a matter of fact, regarding the working conditions of the health staff "the poor working conditions of many health professionals should also be framed as forms of disrespect and abuse, as well as the consequences of being socialised within – and driven to exercise – violence."[254]

Obstetric services should be available 24/7 and include the possibility to be attended in case of emergency or complicacies. Quality obstetric care is essential to improve health and procedures that otherwise could have negative outcome, including to improve the rate of maternal mortality of the most vulnerable women.[255]

States commit themselves through the signature and subsequent ratification of several conventions. For example, in the International Covenant on Civil and Political Rights, it is the state that takes the

[253] Ibid p. 171

[254] Sadler M., Santos M. JDS, Ruiz-Berdún D. et al. (2016). Moving beyond disrespect and abuse, pp. 24-47. Available at http://dx.doi.org/10.1016/j.rhm.2016.04.002

[255] UNICEF. (2016). Informe sobre Equidad en Salud 2016, p. 12

burden of make the enjoyment of right possible to everyone without discrimination of any kind (Article 2 (1)), including through the adoption of new national laws if not already existing (Article 2(3)) as well as it guarantees to all people to whom the rights have been violated, an effective remedy by a competent authority. Article 3 recognizes that the state must ensure the equality in rights between women and men and the protection of the family as natural and fundamental group unit of society. The same is the International Covenant on Economic, Social and Cultural Rights[256]. The State is committed to make rights enjoyable without discrimination of any kind of the rights enshrined in the Covenant as well as the right to the enjoyment of the highest attainable standard of physical and mental health at Article 12.1.

In addition, states are responsible for providing services that include access to the right to enjoy the right to health. These services include the underlying determinants of health that are listed in a General Recommendation by the Committee on Economic, Social and Cultural Rights. As reported in the right to health[257], hospitals, clinics and other health-related buildings (within safe physical reach, including in rural areas and affordable for all, including socially disadvantaged groups[258]), trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.[259]

It is therefore important to note then, that the state is not limited to the provision of health facilities and of the health personnel but it must also guarantee the services that support the material structure, for example the supply of potable water and food for pregnant women. Emphasis must be put also on the importance of the working conditions of the medical staff who must be dignified since, as we have seen previously, many cases of obstetric violence arise from difficult working condition for the health personnel which then releases their frustration on the patient. Furthermore, it is always role of the state, the provision of adequate coverage within its territory, including rural areas to reach those sectors of the population that have usually a more difficult accessibility to these facilities and services.

The same General Comment further recognises that the right to health contains four interrelated and essential elements[260], the precise application of which will depend on the conditions prevailing in a particular State party.

Finally, it is always the task of the state to recognize and implement the right to health through its national policies, including and, if necessary, changing its laws to provide its population with the highest attainable standard of physical and mental health.

[256] UN General Assembly, International Covenant on Economic, Social and Cultural Rights. 16 December 1966. Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

[257] Committee on Economic, Social and Cultural Rights. General Comment No. 14: The Right to the Highest Attainable Standard of Health. 11 August 2000, para 11

[258] Ibid para 12(b)

[259] Ibid para 12(a)

[260] For more information about the four interrelated and essential elements refer to chapter 3, section 1, Right to Health

Still in this context, it is the duty of the state to eliminate all those sources from which prejudices and stereotypes arise and that consider one of the two sexes as superior in comparison to the other.
In the CEDAW, states parties undertake to adopt all necessary measure to make possible the full enjoyment of the rights of the convention (Article 24). So, States Parties are committed to eliminating any form of discrimination against women, enhancing the equality between men and women also in the field of health and the services to make available to pregnant women and babies (Article 12(2). They have also assumed the obligation to eliminate patterns of conduct that could influence discrimination.
In the Convention against Torture, States Parties made the commitment to "establish its jurisdiction over the offences [that can occur] (a) […] in any territory under its jurisdiction […]; (b) When the alleged offender is a national of that State; (c) When the victim is a national of that State if that State considers it appropriate" (Article 5).
For what concerns children's rights, States must all appropriate measures to ensure them protection against discrimination, the enjoyment of their rights and, inter alia, the enjoyment of the highest attainable standard of health (Article 24). The same rights are committed by States Parties in the Convention on the Rights of Persons with Disabilites (Article 2 on non-discrimination and Article 24 on Health).
Many states are also compromised at international level even with non-binding documents. An example is the Program for Action of Cairo. The 179 governments taking part in the Conference on Population and Development adopted an Agenda for a global development to pursue in the following years. They made it, aware of the fact that "many of the quantitative and qualitative goals of the […] Programme of Action clearly require additional resources that, as stated in the document, could be more or less expensive. Among the less expensive the initiatives to make changes in lifestyles, social norms or government policies (para 1.13).
The following year, representatives of 189 governments gathered at the Fourth World Conference on Women in Beijing and adopted the agenda for women's empowerment. Governments are called to take measures to improve in twelve critical areas, implementing their internal legislation where necessary. This great commitment has indeed led to an improvement in the living conditions of many women and a more active presence of women in social life.

In the Inter-American system, the American Convention sanctions to his article one that States Parties are compromised to "respect the rights and freedoms recognised" in the Convention and with the

Protocol of San Salvador (Article 15(3)(a))[261] "to provide special care and assistance to mothers during a reasonable period before and after childbirth."
As well as in Belem do Para, Article 9 states that States Parties shall take special account of the vulnerability of women, among other characteristics, while pregnant.

3.1 Current status of the rights

An interesting report by Amnesty International[262] shows that in many states of Latin America and the Caribbean, there is an almost systematic violence for women seeking assistance in health facilities. As emerges from the report, apart from "laws or practices that violate sexual and reproductive rights" states can generate other forms of violence which include "ill-treatment and denial of services in health-care institutions; breaches of patient confidentiality; the imposition of certain moral or religious views on women and girls; and multiple discrimination."[263]
Especially for what concerns Latin America and the Caribbean, the mistreatment of patients is widespread in the health facilities and the situation is aggravated in the case concerning the access to health services related to the reproductive rights. In Mexico, for example, the Comisión Nacional de Derechos Humanos has issued various general recommendations with respect to the theme of mistreatments suffered in health facilities after having received numerous complaints from citizens. In particular, in 2002[264], it issued a recommendation regarding the lack of information towards Indigenous people as health facilities did not propitiate to indigenous population members, adequate family planning modalities.
The gynaeco-obstetric field is the medical field that receives most often complaints of abuse at all.

3.2 Discrimination within dedication

At this point in the study, it is useful to have a look at the real architects of obstetric violence, i.e. those employees of the state who actually put it into practice: the health personnel. In the first chapter

261 OAS, Additional Protocol to The American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. "Protocol of San Salvador". San Salvador, El Salvador, 17 November 1988.
262 Amnesty International. (March 2016). The State as a Catalyst for Violence Against Women. Violence Against Women and Torture or Other Ill-Treatment in the Context of Sexual and Reproductive Health in Latin America and the Caribbean
263 Ibid. p. 8
264 Comisión Nacional de los Derechos Humanos. Recomendación General Número 4 derivada de las prácticas administrativas que constituyen violaciones a los derechos humanos de los miembros de las comunidades indígenas respecto de la obtención de consentimiento libre e informado para la adopción de métodos de planificación familiar. Mexico D.F. December 2002. Available at http://www.cndh.org.mx/sites/all/doc/Recomendaciones/Generales/RecGral_004.pdf

we have already seen that many times the problem arises because of the difficult work conditions as the low resources and equipments, long and heavy shifts and poor work environment.

In reality, obstetric violence has deeper roots. It also refers to patriarchy as in chapter 1, section 3.1. In fact, in many cases, it derives from the same teachings that doctors have learned during their years of study and in the field as medical students and future doctors. In fact, they will later repeat these practices once they become full-fledged physicians and teach them to the following medical students in an endless spiral.[265] Roberto Castro[266] argues that during the years of training, medical students learn how the punishment can be used to teach, discipline and to build a hierarchical situation between the parties, thanks to the health system that is strictly hierarchical structured, too.[267]

In this regard, over the years, codes of conduct for doctors, nurses and all the health personnel were born and many hospitals have adopted them in behalf of their employees. These codes of conduct very often specify also rules of etiquette and responsibilities to other members of the profession.[268]

The first and perhaps the most famous and ancient code of conduct for medical staff is the Hippocratic oath, a text written in 400 BC supposedly by the Greek physician Hippocrates and modernized in the last century to be actual.

In many medical schools today, before formally starting the exercise of their profession, doctors and odonatologists still swear to it. In the original version, the doctors call upon Greek gods and swore to abstain from surgical operations for example and that is why it has been modernised in the 60s. Already in the original text, among the verses to be recited, there was the commitment to no overtreat patients and to respect patients' privacy. Subsequently, the oath made all physician remember how to treat patients properly, keeping in mind that illness of the patient may affect the person's family and economic stability.[269]

Later on, in the 70s, codes are no longer sufficient and thus the discipline of bioethics was born. It concerns the ethics applied to the various biological aspects of a person's life.

It is therefore important to remember the four principles of bioethics, the base on which all doctors, nurses and other health personnel must support. These principles are:[270]

- Principle of autonomy

[265] This idea is discussed in detail by Roberto Castro, one of the maximum experts in obstetric violence

[266] Castro R. (April-June 2014). Génesis y práctica del habitus médico autoritario en México. Revista Mexicana de Sociología, vol. 76, No. 2, pp. 167-197.

[267] Ibid. p. 179

[268] Beauchamp T. L., Childress J. F. (1994). Principles of Biomedical Ethics. New York, U.S.A.: Oxford University Press, p. 7

[269] Whilst the original version written by Hippocrates expected health personnel to swear on different Gods, the modern version, which is usually the one accepted in some medical schools and here referred, is the version of 1964, written by the Decan of the School of Medicine at Tufts University, Louis Lasagna.

[270] Ibid at 267, pp. 120-394

- Principle of nonmaleficence
- Principle of beneficence
- Principle of justice

The principle of autonomy asserts the freedom of a person in accordance with a self-chosen plan.[271] This principle of being autonomous includes the principle of being respected as an autonomous agent, too. This includes the person's right to hold views, to make choices, and to take actions based on personal values and beliefs. As explained by Beauchamp and Childress "such respect involves respectful *action,* not merely a respectful *attitude*."[272]
It is also recognised the indispensable necessity, in order to make this principle true, to have information and the presence of material cooperation of others in making options available. That is why professional must disclose information to allow to probe and ensure understanding and voluntariness as well as to foster adequate decision-making. Under the explanation of this principle, it is then possible to recognize the attitude that some medical personnel have to establish a relationship of authority and dependence instead of fostering patients' autonomy.[273]
Furthermore, this principle is the basis of the so called informed consent.

The principle of nonmaleficence consists instead in the obligation not to inflict harm intentionally to the patients that is the obligation to refrain to take actions that can harm (through both actions or omission) or not imposing risk of harm. It reflects the maxim *Primum non nocere:* first do no harm. Nevertheless, it might happen that medical staff cause harm unintended or unaware however the harm inflicted was not intentional. [274]
In close connection with the principle of nonmaleficence, there is the principle of beneficence that is the principle according to which not only medical personnel refrain from hurt people but also enhance their welfare taking positive actions.

The principle of nonmaleficence could be seen as the contrary of the principle of beneficence. but in reality nonmaleficence involves the fact that "one ought not to inflict evil or harm", whilst beneficent include "one ought to prevent evil or harm, one ought to remove evil or harm, and one ought to do or promote good."

[271] Ibid p. 121
[272] Ibid p. 125
[273] Ibid p. 127
[274] Ibid. pp. 188-196

Therefore, the principle of beneficence requires taking positive actions whilst the principle of nonmaleficence only requires intentionally refrain from taking actions that might harm. [275]

And finally, the principle of justice is the principle according to which medical goods and services must be equally distributed among patients. This principle is especially important in those facilities which lack of goods and possibility of treatments. Despite the fact that the right to a decent minimum of health care should rule, in many cases health care resources have to be allocated among many patients. The principle is based on the duty to treat all patients with equality and thus the duty of medical staff not to make difference among their patients on any basis of discrimination.[276]

4.Issues of intersectionality

The concept of intersectionality[277] was coined by the jurist Kimberle Crenshaw at the end of the 80s. The issue that Crenshaw questioned was that, in legal terms, a single person can often fall into more discriminating categories. More precisely, Crenshaw raised the problem of African American women in the United States who can be both victims of sexism as women and of racism as African Americans. In the end, they are victims of discrimination as women and as African-Americans, but they are actually just one person who had been denied of a right: an Afro-American woman. The problem had in part already been raised by the author bell hooks of *Ain't I A Woman?: Black women and feminism* in 1981. Bell hooks wrote about the continue devaluation of black women since the slavery during the 19th century throughout the modern history. Crenshaw took up the thread years later.
Almost thirty years after the creation of the term, there have been some important changes within the society thanks to this new concept, for example regarding the division of the feminist movement. It brought in fact the distinction between white feminism, that section of feminism that claims a greater role for women in the society but which just refers to white women, leaving aside the rights of all other women like Afro-American women, Latin women, indigenous, Muslim women, etc. These feminist movements are instead part of the so called intersectional feminism. Unfortunately, there is still much to do and still today, for example, an Afro-American woman will often have to understand if she has been discriminated as a woman or as an Afro-American.

[275] Ibid pp. 190-193
[276] Ibid p. 327
[277] Crenshaw K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum, Vol. 1989, iss. 1, Article 8. Available at: http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

In sum, the concept refers to the recognition of the fact that there is not only one type of discrimination against women, the one which is based on the difference between men and women, but there is also a contemporary discrimination against certain groups of women with respect to others.

As said, Cresnshew explained the concept of intersectionality taking as example the case of African-American women and, as evidences, three US juridical cases. However, the concept can apply to an infinite number of possible variations among countless characteristics. In the case of obstetric violence, for example, this concept applies to many of the women who are victims of such violence. Certainly, they are victims of obstetric violence as women, but there are categories that are doubly disadvantaged in access to health facilities and care at the time of pre-, post-partum care and during their delivery. These women are above all immigrant women, women of color, women belonging to minor ethnic groups and indigenous women, women who come from rural areas or from the most disadvantaged or poor sections of the population, women with disabilities or HIV-positive women. For example, the concept of intersectionality applies in the context of obstetric violence when the rights to privacy, information and consensual information (to name a few) of an indigenous woman who comes from a disadvantaged socioeconomic status are violated. In the context of health, people in rural areas, poor and minorities are indeed those who have less possibility to access health facilities. "This intersectionality is what contributes to double and sometimes multiple stigmas and stigmatization […]."[278]

4.1 Intersectionality in the access to health services

As stated by Marie-Paule Kieny, "the world's most disadvantaged people are missing out on even the most basic services. A commitment to equity is at the heart of universal health coverage. Health policies and programmes should focus on providing quality health services for the poorest people, women and children, people living in rural areas and those from minority groups."[279]

Despite the fact that the right to health should be enjoyed by all human beings without any form of discrimination such as gender sex, language, religion, ethnicity, political or other opinion, social origin, property, birth or other status and in spite of the good results Latin America has obtained about the improving of the access to health care in recent decades, there are still great inequality between people who can access to health facilities, women who cannot and women who are able to do so but suffer discrimination and mistreatments for different reasons. For example, a Guatemalan indigenous

[278] Shalini Bharat. Racism, Racial Discrimination and HIV/AIDS. Paper Prepared for the "UNESCO/OHCHR Workshop to Develop Educational Material to Foster Tolerance and to Eliminate Prejudice" at Paris, France, 19-20 February 2002. Tata Institute of Social Sciences, Mumbai, India, p. 5. Retrieved from www2.ohchr.org/english/issues/racism/docs/racismaids.doc

[279] Dr Marie-Paule Kieny, Assistant Director-General, Health Systems and Innovation, at the World Health Organization

woman from a rural area who searches for maternal care must face the difficulty to be a woman in a social contest where women have a lower role, often victim of violence and abuse of power. Often, husbands are the ones who forbid women of their community to have access to health for them and their children. For this and many reasons more, many Guatemalan indigenous women are in fact reluctant to seek health care in public facilities and prefer to be treated with traditional methods typical of their culture rather than modern methods. When they finally decide to go for a public facility, it often results in a negative experience. After being discriminated as women, they must face the difficulty of being an indigenous woman, with the stigma that this entails. The linguistic barriers and the poor literacy they usually have are other elements to add to the whole situation.

As a matter of fact, in many cases the survival to pregnancy and childbirth of a women is strictly related to her social, economic and cultural status. In this regard, in connection with the concept of intersectionality, there are the social determinants of health which intersect the discrimination based on gender who women must face daily. The social determinants of health refer to the "conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries."[280] The fact that many people present certain characteristics relies on these determinants which, at the same time, can be the base for discrimination.
Indeed, the so called social determinants of health of the WHO illustrate how people from certain social classes are more likely to have difficulty in accessing the same services. This is true for people from a lower social status and even more true, for women from a lower social status, a situation which entails disastrous consequences for their health and life expectancy. Not only are people from the lowest levels of economic, social and cultural status discriminated in the access to these services but they are also more likely to be discriminated once they managed to access to these services when they receive health attention.

4.2 Situation in Latin America

Data from Latin America, make us understand that the phenomenon of intersectionality is very often present. Latin America and the Caribbean count with between 45 and 50 million peoples who belong to almost 600 indigenous groups.[281] Indigenous peoples make up to 40 per cent of the rural population

[280] WHO. (n.d.). About social determinants of health. Retrieved 02 February 2018, from http://www.who.int/social_determinants/sdh_definition/en/
[281] UN Department of Economic and Social Affairs. (2017). The State of the Worlds. Indigenous Peoples. New York, p.84

in the region, where there is often little or no access to health services.[282] They experience high levels of poverty and marginalization, especially among women[283]

These Indigenous communities experience discrimination when looking for a job, economic opportunities and social services on the basis of their ethnicity.[284] But women belonging to Indigenous communities have even more difficulties to obtain the same treatment.

These particular groups of women from ethnic or racial groups can in fact face greater risk of forced sterilization, forced pregnancy or restrictions on the number and spacing of children."[285]

Therefore, if obstetric violence can be discriminating against women, it will be even more discriminating for some sectors of the population that, in Latin America, correspond to poor women, those who live in rural areas, indigenous or Afro-descendant race women or adolescents.

A report from the OAS confirms that and shows that some groups of women have more difficulty accessing maternal health services.[286] Especially concerning adolescents, the proportion of young mothers in the indigenous population is higher than that of the non-indigenous population. Brazil is one of the countries that show more inequality: indigenous adolescent mothers in Brazil are the 27% whilst and non-indigenous adolescent mothers are only of 12%. In Paraguay the difference is 45% versus 11%.[287] Form this data it is possible to understand that the problem lies in the fact that girls usually lack sexual education and many of them live in rural areas where there are no health facilities and where education and family planning services are not available.[288]

The concept finds itself in strong contrast with what is stated for example in Article 2 of the American Declaration according to which "all persons are equal before the law and have the rights and duties established in [the] Declaration, without distinction as to race, sex, language, creed or any other factor."

At regional level it is also necessary to underline the presence of two important tools that have been signed by some states in 2013. Nevertheless, they have still not been ratified by many countries. For example, one of these, the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance refers to the concept at Article 1(3): "multiple or aggravated

[282] Ibid. p.89
[283] PAHO, WHO. Health in the Americas Summary: Regional Outlook and Country Profiles, Washington, D.C., p. 120
[284] Ibid.
[285] UN Human Rights Council. (June 2017). Impact of multiple and intersecting forms of discrimination and violence in the context of racism, racial discrimination, xenophobia and related intolerance on the full enjoyment of all human rights by women and girls.
[286] OAS. (2010). Acceso a Servicios de Salud Materna desde una Perspectiva de Derechos Humanos. Washington D.C
[287] UN Inter-Agency Support Group on Indigenous Peoples' Issues. (June 2014). The Health of Indigenous Peoples. Thematic paper towards the preparation of the 2014 World Conference on Indigenous Peoples. New York, p. 7
[288] Ibid

discrimination is any preference, distinction, exclusion, or restriction based simultaneously on two or more of the criteria [previously set], or others recognized in international instruments […]."

At regional level, as well as at international level, there are only references to intersectionality and no direct ruling on the issue. However, the concept should be very present since the great percentage of indigenous people living throughout the Mesoamerica, half of whom are women who are victims of a double discrimination, that is, for being a woman and for being indigenous.[289]

The Inter-American Commission of Human Rights has provided a series of tools such as reports, recommendations and comments to the Court where the theme of the multiple discrimination people face is addressed. For example, the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people stated that indigenous women experience discrimination at three levels: as indigenous persons, poor people, and women. She later added also as rural inhabitants.[290] The report was specifically referring to Guatemala, nevertheless, in many other countries of Latin America, women face multiple discrimination as in the cases here reported, where a double or multiple discrimination has been recognised in the final judgment.In the case Ines Fernandez Ortega v. Mexico, the Commission, referring to the barriers of access to justice by indigenous women, speaks of "multiple discrimination" because the alleged victim was a woman, indigenous, and poor."[291] The case concerns the violence against an Indigenous woman of the community Me'phaa who was raped by some militaries whilst in her house with her four children. The case cited also the difficulties encountered by indigenous people, indigenous women in particular, to obtain access to justice.[292] These barriers can be particularly serious, since they represent forms of "multiple discrimination" because the alleged victims are women, indigenous, and poor. Particularly, in cases of rape of indigenous women, the investigators frequently refute the complaints and place the burden of proof on the victim; in addition, the investigation mechanisms are flawed and even threatening and disrespectful."[293]

Among the difficulties indigenous women can have in reporting assault, and among those faced by the same Ines Fernandez Ortega, the Commission recognised the "cultural, economic and social, as well as language barriers" as well as "resistance, silence, negligence, harassment, fear, revictimization

[289] Inter-American Court of Human Rights. (2007). Acceso A La Justicia Para Mujeres Víctimas De Violencia en las Américas, para 198. Available at http://www.cidh.oas.org/pdf%20files/Informe%20Acceso%20a%20la%20Justicia%20Espanol%20020507.pdf

[290] Yakin Ertürk. (10 February 2005). Integration of the Human Rights of Women and the Gender Perspective. Violence Against Women Report of the Special Rapporteur on violence against women, its causes and consequences. Addendum Mission to Guatemala, para 15.

[291] Fernández Ortega et al. v. Mexico (Inter-American Court of Human Rights 30 August 2010), para 185. Available at http://www.corteidh.or.cr/docs/casos/articulos/seriec_215_ing.pdf

[292] Ibid para 2

[293] Ibid para 185

[in] a forum that lacks jurisdiction and interest in seeking those responsible, among many other obstacles."[294]

In the case Lluy et al. v. Ecuador,[295] the victim is a child, Talía Gonzales Lluy, who had been infected with a blood transfusion at the age of three. The child contracted HIV and since then, she has been stigmatised for that. As her school became aware of her HIV positive status, Talía was expelled and despite her efforts to find other schools where to study, she was not accepted by any of them with serious repercussions on her education. As a consequence, Talia has been denied the access to education in contravention of the rights of the child (the Court considers that the Ecuadorian State violated the right to education of Talía Gonzales Lluy contained in Article 13 of the Protocol of San Salvador, in relation to Articles 19 and 1(1) of the American Convention).

The Commission approved the admissibility of the complaint and the State of Ecuador was also found responsible for the violation of the right to life (Article 4) and the right to humane treatment (Article 5) [296] since it failed to protect Talia. The State had to answer for the actions of the health facility and the blood bank from where Talia had received the infected blood which had not been previously tested.

Not only the girl was affected by the disease, though. Her mother was fired from her job from ten years since she had a HIV positive daughter and could not find a new one for the same reason[297] and her brother had to leave university to work and provide for the family. The precarious economic conditions of the Gonzales Lluy family worsened further in the years following the diagnosis. In fact, the State of Ecuador was held responsible for the violation of Talia family's right to physical, mental, and moral integrity (Article 5.1) for the difficulties her mother and her brother had to face after the stigmatisation the received for being part of the same family of a HIV positive people.[298]

The Court considered that "discrimination against Talía has been associated with factors such as being a woman, a person living with HIV, a person with disabilities, and a minor, and also her socio-economic status."[299] But it also recognised that these numerous factors of vulnerability and risk of discrimination **intersected** (in bold as in original) and the discrimination Talia suffered, was the result of the intersection of all those factors and not by one in particular who prevailed over the other.

[294] Ibid para 133
[295] Gonzales Lluy et al. v. Ecuador (Inter-American Court of Human Rights 1 September 2015). Available at http://www.corteidh.or.cr/docs/casos/articulos/seriec_298_ing.pdf
[296] Ibid para 190-191
[297] Ibid para 289
[298] Ibid para 229
[299] Ibid para 291

Indeed, if one of those factors had not existed, the discrimination that Talia suffered, would have been different. [300]

Furthermore, the Court admitted that "certain groups of women suffer discrimination throughout their life based on more than one factor combined with their gender, which increases their risk of enduring acts of violence and other violations of their human rights."[301]

The third case to cite is the case Hermanas González Pérez v. México,[302] of violence against women from the Tzeltal indigenous community. The victims are three sisters, Ana, Beatriz, and Celia González Pérez and their mother Delia Pérez. In June 1994, they were stopped for an inspection by some soldiers at a military checkpoint for two hours. The four of them did not speak Spanish. Militaries stopped and interrogated them to elicit a confession of their affiliation to the Zapatista Army of National, EZLN (Ejercito Zapatista de Liberacion Nacional), a rebel movement that intended to fight for the rights of the indigenous population, born in the 80s and led by Subcomandante Marcos. The movement declared an open war against the Mexican government asking for bread, health, education, autonomy, and peace for all the *campesinos* of the state of Chiapas.[303]

During the hours the four women spent at the checkpoint, the three sisters were separated from their mother and were repeatedly beaten and raped at the presence of 30 soldiers, many of whom took part of the acts. When they were released, military threatened them to death in order to prevent them from reporting. The sisters, in fear of reprisals, did not report until few weeks later (only the two eldest sisters reported, the little sister did not report). The violence had a severe impact in the life of the four women: they had to flee their communities and families as a result of the humiliation created by the abuse they had been victim of.[304]

The Commission declared the case admissible and the state of Mexico was fond responsible for the violation of the right to personal freedom and security (Article 7 of the American Convention) as for the illegal detention of the four women in the checkpoint and their right to honour and dignity as in Article 11 of the American Convention. In addition to that, the State violated also the right to be free from torture and (Article 5 of the American convention and Article 8 of the American Convention to Prevent and Punish the Crime of Torture) as well as child rights (Article 19 of the American Convention) with regard to the youngest sister.[305]

[300] Ibid para 290
[301] Ibid para 288
[302] Ana, Beatriz and Celia Gonzalez Perez v. Mexico (Inter-American Commision on Human Rights 4 April 2001). Available at http://cidh.org/annualrep/2000eng/ChapterIII/Merits/Mexico11.565.htm
[303] Castronovo V. (2007). Piazza e caserme. I dilemmi dell'America Latina dal Novecento a oggi. Bari: Editori Laterza, pp. 225-229
[304] Ana, Beatriz and Celia González Pérez v. Mexico, report No. 53/01, para 13
[305] Ibid para 4

The most important fact for the purposes of this section that the commission emphasizes is the conclusion that "the pain and humiliation suffered by the women was aggravated by their condition of members of an indigenous group. First of all, because of their lack of knowledge of the language of their aggressors and of the other authorities; and also because they were repudiated by their own community as a consequence of the violations" they suffered.[306] Furthermore, the commission recognised that

Among the cases of forced sterilisations which have been judged by the inter-American system of human rights, the case of F.S. v. Chile may be relevant under the lens of intersectionality. Francisca, a HIV-positive woman from Chile, has been sterilised without her consent when she underwent a caesarean surgery for the birth of her first child. The case was declared admissible by the Inter-American Commission of Human Rights in 2014[307] and in March 2017 the Commission gathered for a hearing. This case is important because it is the first case of forced sterilisation of a HIV-positive pregnant woman in Latin America to be judged by an international human rights body. The applicant, together with the associations Center for Reproductive Rights and Vivo Positivo asked for the recognition of the violation of the rights to personal integrity, due process, access to information, privacy and family life, non-discrimination, judicial protection and her right to be free from violence[308] contending that "this kind of coercion reflects a deeply-rooted discrimination against women living with HIV."[309] This case will be possibly considered as a landmark for tackling the discrimination against HIV-positive women in Latin America and in the world since, as recognised by many international bodies: "in some countries, people belonging to certain population groups, including people living with HIV, persons with disabilities, indigenous peoples and ethnic minorities, and transgender and intersex persons, continue to be sterilized without their full, free and informed consent." [310] The report also recognises that historically, women have been disproportionately subjected to forced, coerced and otherwise involuntary sterilization and they face this type of coercion on the ground of "multiple and intersecting grounds, because they are women, live with disability or HIV and/or belong to indigenous populations or ethnic minorities."[311]

[306] Ibid para 95
[307] Report of admissibility of the case F.S. No. 52/10, 21 July 2014. Available at http://www.oas.org/en/iachr/decisions/2014/CHAD112-09EN.pdf
[308] Centre for Reproductive Rights. (2017, March 20). Inter-American Commission Holds Hearing on Forced Sterilization of Chilean Woman Living with HIV [Press release]. Retrieved 15 February 2018, from https://www.reproductiverights.org/press-room/inter-american-commission-holds-hearing-on-forced-sterilization-of-chilean-woman-living-w
[309] Ibid at 306, para 17
[310] WHO, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, and UNICEF. (2014). Eliminating forced, coercive and otherwise involuntary sterilization. An interagency statement. Geneva, Switzerland. Available at http://apps.who.int/iris/bitstream/10665/112848/1/9789241507325_eng.pdf?ua=1
[311] Ibid p. 3

In conclusion, the regional system of human rights recognizes the fact that in many cases of its competence, violence is addresses towards victims on different contemporaneous grounds since the victims are women who come from one of the most vulnerable sectors of society as may be the case of indigenous, poor or impaired women. The Court and the Commission also recognise the difficulty these people have in accessing justice for the crime they suffered due to economic, geographical factors as well as social and cultural reasons, and, of course, due to their condition of women from vulnerable sectors. They also are aware of the stigmatisation they suffer during their lifetime and the difficulties they have to face as victims of the violation of their rights. That is an important recognition at regional level due to the high rate of violence against women throughout the region and especially, with respect to the discrimination that a great percentage of these women experienced based on their ethnicity.

6. Is there any international framework?

The actual problem that intersection face is the lack of a formal addressing by international organisations, issue which came to the fore in recent years.

As a matter of fact, intersectionality cannot be found in hard law at international level yet. For example, there is a CEDAW against the discrimination against women and a Conventions on the Elimination of all Forms of Racial Discrimination as well as there is a Convention on the Rights of Persons with Disabilities but all of them just focus on one discriminated category.

Actually, the Convention on the Rights of Persons with Disabilities cites the concept but only in its preamble: "concerned about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status."[312]

Beijing, at the time, pointed out the difficulty of women from poor areas to be able to have access to health services. "The main obstacles to obtaining skilled assistance in childbirth in Latin America and the Caribbean include the lower availability of medical personnel in rural and low-income areas; the great distances to health centres and the logistical difficulties to reach them; the costs associated with care and the perception that health centres have poor quality services or do not attend well."[313]

A breakthrough could have been possible more recently, with the UN Declaration World Conference against Racism, signed in 2001. The declaration's aim was to fight racism and discrimination

[312] UN General Assembly, Convention on the Rights of Persons with Disabilities. 2002, Preamble (p)
[313] UNICEF. (2016). Informe sobre Equidad en Salud 2016, p. 13

committing States Parties in taking action a different level. It also recognises that "victims can suffer multiple or aggravated forms of discrimination based on other related grounds such as sex, language, religion, political or other opinion, social origin, property, birth or other status"[314]

Despite the good intentions, the declaration was a failure due to the abandonment of the delegations of the USA and Israel after some divergencies in the topic of Zionism, but above all because of the attacks on the twin towers which took place three days after the conclusion of the works that led to a cancellation of what had been done until then.

In spite of the almost complete absence from legally binding instruments such as international conventions, it is possible to read some clues of intersectionality in many documents of soft law such as reports from the committees appointed to the various areas of human rights. For example, in the last years, some of the non-binding documents who address the issue are:

The General Recommendation No. 18 on Disabled women[315] which in its preamble recognizes the double discrimination disabled women suffer.

In 2001, Pragna Patel cited the idea of intersectionality and gave it a good overview: "[it] seeks to capture both the structural and dynamic consequences of the interaction between two or more forms of discrimination or systems of subordination. It specifically addresses the manner in which racism, patriarchy, economic disadvantages and other discriminatory systems contribute to create layers of inequality that structures the relative positions of women and men, races and other groups."[316]

In April 2002, the UN recognised "the importance of examining the intersection of multiple forms of discrimination, including their root causes from a gender perspective"[317] after "noting with concern that women and girls are often subject to multiple forms of discrimination on the grounds of their gender as well as their origin"

The CEDAW General Recommendation No. 26 on Women Migrant Workers added that "women migrant workers often experience intersecting forms of discrimination, suffering not only sex- and gender-based discrimination, but also xenophobia and racism."[318]

[314] Declaration of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance. Durban, South Africa, 31 August - 8 September 2001. Available at http://www.un.org/WCAR/durban.pdf

[315] Committee on the Elimination of Discrimination against Women, General recommendation No. 18 on disabled women. 1991

[316] Pragna Patel. Notes on Gender and Racial Discrimination: An Urgent Need to Integrate an Intersectional Perspective to the Examination and Development of Policies, Strategies and Remedies for Gender and Racial Equality. 31 October 2001, para 23

[317] Commission on Human Rights, Report on The Fifty-Eighth Session, 18 March-26 April 2002. Para 1

[318] Committee on the Elimination of Discrimination against Women, General recommendation No. 26 on women migrant workers, Article 14. 5 December 2008

General recommendation No. 27[319] on older women and protection of their human rights recognises that age is one of the grounds on which women suffer multiple forms of discrimination." It returned then to talk about multiple forms of discrimination.

Finally, the most complete definition is perhaps given in the General Recommendation No. 28 on the Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women.[320] There are no more double or multiple discriminations in the General Reccomendation but, as in the CEDAW two years earlier, intersectionality in Article 18 "is a basic concept […]. The discrimination of women based on sex and gender is inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste, and sexual orientation and gender identity. Discrimination on the basis of sex or gender may affect women belonging to such groups to a different degree or in different ways than men." The article subsequently committed states to recognize and prohibit such intersecting forms of discrimination."

Nevertheless, the lack of addressing about the concept of intersectionality is notices also by the Special Rapporteur Report of the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo. In 2011 where he points out a continuous lack of response to the problem of intersectionality.[321]

In the Annual report of the United Nations High Commissioner for Human Rights about the impact of multiple and intersecting forms of discrimination and violence in the context of racism, racial discrimination, xenophobia and related intolerance on the full enjoyment of all human rights by women and girls[322], the problem is analysed from different point of view and state policies and gaps to be filled are illustrated.

First of all, it identifies as marginalized communities, those communities who live in areas where it is more difficult to access to basic services and where some others are missing or lacking such as transports and inadequate housing and sanitation and where there is a higher level of insecurity and violence, too. In this regard, it brings an example: "according to the United Nations Development Programme (UNDP), the level of poverty of an Afro-Ecuadorian woman living in rural areas accounts for 87.3 per cent per unsatisfied basic needs, while the average of an urban Afro-Ecuadorian woman

[319] Committee on the Elimination of Discrimination against Women, General recommendation No. 27 on older women and protection of their human rights, Articles 1; 2; 9. 4-22 October 2010

[320] Committee on the Elimination of Discrimination against Women, General Recommendation No. 28 on the Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women, 4-22 October 2010

[321] Rashida Manjoo, Report of the Special Rapporteur on violence against women, its causes and consequences, 28 May 2014

[322] Human Rights Council, Impact of multiple and intersecting forms of discrimination and violence in the context of racism, racial discrimination, xenophobia and related intolerance on the full enjoyment of all human rights by women and girls, June 2017

is 62.2 per cent. Statistics also show that women of African descent have less access to housing, health and education than men of African descent and women not of African descent."[323]
Furthermore, it denounces how "women and girls affected by intersecting forms of violence and discrimination often lack access to information about the availability of services, their rights and entitlements." This is because in many cases no appropriate services are available for them "often because of an inability to adequately communicate or understand their cultural practices"[324] as well as linguistic barriers.

After having analysed the concept of intersectionality, it is now necessary to analyse more in detail the application of the concept to the jurisprudence to see if it is taken into account by the courts and if so, in which situations and to what extent it is applied to the case. Here listed below it is possible to find cases that refer to the intersection of different basis of discrimination.
Regarding international cases on this subject, we can find references to intersectionality in some cases judged by UN Committee on the Elimination of Discrimination Against Women. It is important to clarify that none of the cases specifically address the concept of obstetric violence and more often the cases are not read with the lens of intersectionality. Nevertheless, it is possible to notice some references to it in some of the paragraphs of the final conclusions or reports.

The first case took place in Brazil and concerns a woman, Mrs Pimentel who was not carefully attended by health personnel when she was in severe pain during her pregnancy and eventually died after receiving treatment in a hospital. She was an Afro-Brazilians woman and received poor health care after her baby died in her womb.
The UN Committee on the Elimination of Discrimination Against Women recognised that the woman "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."[325] The case of Alyne Silva da Pimentel v. Brazil will be treated with more details in the next chapter.

The A.S case v. Hungary[326] deals with a Hungarian Roma woman victim of forced sterilisation. She was in a local hospital as a result of a natural abortion during her fourth pregnancy. Already anesthetized and in the operating room stretched out on the operating table and ready for the

[323] Ibid para 18
[324] Ibid
[325] Alyne da Silva Pimentel Teixeira (deceased) v. Brazil (UN Committee on the Elimination of Discrimination against Women), para 7.7
[326] A.S. v Hungary (Committee on the Elimination of Discrimination against Women 29 August 2004). Available at https://www.escr-net.org/sites/default/files/CEDAW_Committee_Decision_0.pdf

operation, health personnel asked her to sign some documents. At the bottom of one of these, there was the barely readable hand-writing note by one of the doctors which stated that she no longer wanted to remain pregnant and have children and thus consented to undergo a sterilization (the Latin term instead of the word "sterilization" was used, a term she did not know). She knew she had been sterilized only after the operation when she asked to the doctor when she could have become pregnant again. Only at that point, she learned the meaning of the world "sterilization". Being her a Rome woman, sterilisation was against her religion (Christian catholic) as any other similar method of contraception, moreover, it is in stark contrast to the family concept on which Rome's culture and society is based. If conscious and acquainted with what she was reading, Mrs. A.S. would have never signed the consent for the sterilisation.

After the communication was found admissible by the Committee, the case was judged by the UN Committee on the Elimination of Discrimination Against Women and the Hungarian state was found in violation of Article 10 of the Convention on the Elimination of All Forms of Discrimination Against Women with regard to the patient's right to information and the provision of information on contraception and family planning: the consent for a procedure is to be considered valid only if the patient has been given a truthful and complete information as recalled in chapter 3, section 3.2. The state is held responsible also for the violation of Article 12 for the non-discrimination in the health sector as it did not provide "appropriate services in connection with pregnancy, border and post-natal period"[327] and finally of Article 16 (1) (e), for the tying of fallopian tubes as it interfered in the decision of the number and spacing of children of the woman.[328]

In conclusion, it can be argued that the state has failed to protect the reproductive rights of A.S.

However, the court did not sufficiently emphasize the importance of the ethnicity of Mrs. A.S. As mentioned at the beginning, she is a Roma woman living in Hungary. Hungarian Roma are the largest minority living in the country but also the most discriminated. Discrimination against them begins at school[329] it worsens at higher grades of education and when looking for an employment. The problems Roma face in Hungary, have required also the intervention of some international organizations in order to improve the integration and acceptance of this minority within the Hungarian society (some examples are the Roma Action Plan by OSCE in 2003 and the past "Decade of Roma Integration" launched in 2005 by the World Bank and the Open Society Institute (OSI)[330]). Nowadays, discrimination still exists and is constantly expanding. The last case of discrimination against the Roma community was recorded last year when the participants of a demonstration

[327] Ibid para 11.3
[328] Ibid para 16.4
[329] Ministry of Foreign Affairs of Budapest. (2004). Fact Sheets on Hungary. Gypsies/Roma in Hungary. pp. 10-11. Available at http://www.mfa.gov.hu/NR/rdonlyres/05DF7A51-99A5-4BFE-B8A5-210344C02B1A/0/Roma_en.pdf
[330] Ibid p. 12

surrounded houses of members of the community and sang racist choirs throwing stones while the police did not intervene.[331] Given the great importance of the issue of discrimination Roma people have to deal with in Hungary, it is almost clear that the forced sterilisation A.S. suffered was a consequence of a discrimination based on ethnicity, too.

Although the case is considered as a milestone in international jurisprudence for being the first case in ruling about the access to information in the field of reproductive rights, the court totally failed to read the case under the lens of intersectionality since the violation of the rights of A.S. has not been considered under the important aspect of her belonging to an ethnic minority. As Truscan and Bourke-Martignoni pointed out, it could have been highlighted by the Committee when it cited General Recommendation No. 24 on women and health. The Court completely omitted "to refer to the part of the Recommendation that stresses circumstances, other than biological differences, which impact on women's health status."[332] Afterwards, a number of studies[333] have considered this case as a case of intersectionality as well as a report by the CEDAW and a shadow report on the situation of Romani women in Hungary submitted by the ERRC (European Roma Rights Centre)[334] submitted before the meeting for the Committee's concluding comments.[335] The shadow report confirmed that "multiple and/or intersectional discrimination against Romani women is pervasive in Hungary"[336] and considered the case A.S. v. Hungary as an example of discrimination on both the basis of gender and ethnicity. It is possible to state that A.S. has indeed been sterilized as a woman Roma, a common situation in some countries since, as pointed out by an ODIHR's Human Rights Adviser: "in the medical sphere, Romani women often face situations where they are not given adequate information related to their medical condition, where they are not involved in the decision-making process concerning their treatment, or where they are treated as objects instead of clients and are approached with the attitude of "the doctor knows the best"."[337]

[331]Király and Dömötör v. Hungary (European Court of Human Rights 17 January 2017). Available at https://hudoc.echr.coe.int/eng-press#{"itemid":["003-5599395-7074074"]}

[332] Truscan and Bourke-Martignoni. (2016). International Human Rights Law and Intersectional Discrimination. The Equal Rights Review, Vol. 16, p. 112

[333] In this regad: Hodson, L. (2014). Women's Rights and the Periphery: CEDAW's Optional Protocol. European Journal of International Law. 25(2), pp. 561-578, https://doi.org/10.1093/ejil/chu027

[334] European Roma Rights Centre. (2007). Written Comments of the European Roma Rights Centre Concerning Hungary For Consideration by the United Nations Committee on the Elimination of Discrimination against Women at its 39th Session. Available at http://www.errc.org/cms/upload/media/03/7A/m0000037A.pdf

[335] Committee on the Elimination of Discrimination against Women. (2007). Concluding comments of the Committee on the Elimination of Discrimination against Women. Hungary. Available at http://www.un.org/womenwatch/daw/cedaw/cedaw25years/content/english/CONCLUDING_COMMENTS/Hungary/Hungary-CO-6.pdf

[336] Ibid at 334, para 1.4

[337] Danka A. (17 May 2007). In the Name of Reproductive Rights; Litigating before the UN Committee on the Elimination of Discrimination against Women. Retrieved from http://www.errc.org/cikk.php?cikk=2759&archiv=1

The recognition of the discrimination of the victim on a double or multiple basis can be found in some other judgments but none of them in reference to the violation of reproductive rights as in the case of Kell v. Canada[338] concerning property rights on a lodging made available to Indigenous people in an Indigenous community where the victim[339] eventually lived with her partner. Soon after she moved in, her partner started abusing her and even when she found a job, he took control over her finance for a period of three years. Meanwhile, the husband asked for the removal of Kell from the co-ownership of the lodging, achievement he obtained and thus resulting as the only owner of the lodging. Mrs. Kell did not have any more rights on the property which her husband and her obtained thanks to her status as Indigenous. For ten years, Mrs. Kell tried to get her house back, during which time she alledged she did not receive adequate legal representation (she had to change three lawyers assigned to the case) being discriminated by them and by the officials of the housing service board.[340]
In the meanwhile, her partner became ill with cancer and he eventually died before the end of the legal battle but managed to sell the house before his death. Mrs. Kell exhausted all domestic remedies and filed a complaint before the CEDAW claiming the violation of the Articles 1, 2, 16 of the CEDAW by Canadian authority.
Under the lens of intersectionality, she alledged that "as an aboriginal person, she experienced racism, and as a woman, she experienced sexism"[341] and the Court recognised the fact that "an act of intersectional discrimination has taken place against the author."[342] There is then the recognition by an international human rights body of aboriginal people as possible victims of intersectional discriminations.

The case R.P.B. v the Philippines [343] on the other hand, concerns a Filipino girl, deaf and mute, who was 17 when her neighbour raped her. The discrimination grounds of her violence are the sex and the young age which intersected with her disability.
When she denounced the fact, her sister had to interpret for her as no sign interpreter was available. Moreover, the national court failed to provide her accessibility to justice in equality with others as she was not provided with an assistance of sign language interpreters for the whole period of

[338] Cecilia Kell v Canada, (Committee on the Elimination of Discrimination against Women 2012). Availabale at http://www2.ohchr.org/english/law/docs/CEDAW-C-51-D-19-2008_en.pdf
[339] The victim is an aboriginal woman who belongs to the community of Rae-Edzo, in the Northwest Territories in Canada. At the time of the facts, members (and only members) of the Rae-Edzo community could apply for housing at the Rae-Edzo Housing Authority.
[340] Ibid at 338, para 9.3
[341] Ibid.
[342] Ibid para 10.2
[343] R.P.B. v the Philippines (Committee on the Elimination of Discrimination against Women 2014).

investigation and during some hearings in the court. In many hearings, the burden of finding sign language interpreters was placed, at least partly, on the author.[344]

The CEDAW Committee declared the communication of R.P.B. admissible and judged the Philippines responsible for the violation of the Articles 2(c), (d), and (f) of CEDAW, to be read in conjunction with article 1 of CEDAW and General Recommendations No. 18 on disabled women and General Recommendation No. 19 on violence against women. Article 2(c) of the CEDAW refers to the Policy Measures according to which states should guarantee legal protection of the rights of women which should be on an equal basis with men; 2(d) refers to the refrain from engaging in any act or practice of discrimination against women and the compromise of public authorities and institutions to act in conformity with this obligation and 2(f) refers to the commitment to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.

Lastly, the Committee recalled its general recommendation No. 18, where it observed that "disabled women are considered as a vulnerable group […] who suffer from a double discrimination linked to their special living conditions."[345] The case therefore recognizes the existence for R.P.B. of an intersection of at least three discriminating factors: gender, age and disability which are present at the same time and that made of the violence suffered by the young girl, even more severe.

Nevertheless, despite the recognition of the overlap of different discrimination, the Committee conclusions "separate sex and gender, on the one hand, and age and disability, on the other. [It] neither decided on additive discrimination on the basis of sex, gender, age and disability, nor intersectional discrimination. Despite its analysis, it still preferred to operate with a conceptual separation of the applicant's experiences and focus on sex and gender-based discrimination to the detriment of age and disability.[346]

From the study of these cases, it is possible to understand how intersectionality is still far from being fully taken into account by international human rights bodies. This is especially true above all in the field of reproductive rights. Indeed, there have been some changes in the jurisprudence and in some cases, the concept has been recognised into the merits of the cases. However, final judgments do not always solve the case under the perspective of this concept and still prefer to find the state responsible for the violation of human rights according to different separated grounds.

Lorena Susa argues that the problem is perhaps due to the fact that the concept of intersectionality is not present in hard law, perhaps due to the incapacity of the same [hard] law to quickly adapting to

[344] Ibid para 8.6
[345] Ibid para 8.3
[346] Ibid. at 332, p. 119

new developments and where, on the contrary, concepts tend to be crystallised and thus unable to adapt to changing situation.[347] The fact remains that in many cases where the situation could have been better analysed with the intersectionality perspective into be better address, the Court has totally failed to approach it with the lens of intersectionality.

[347] Sosa L. (2017). Intersectionality in the Human Rights Legal Framework on Violence against Women. At the Centre or the Margins? Cambridge University Press: UK, p. 262

CHAPTER 4. Obstetric violence in the wards

Contents: 1. Obstetric violence in concrete; 1.1 Venezuela. Ten years later; 1.2 México and its Tribunal Simbólico; 1.3 Situation in Argentina; 1.4 In Brazil; 2. The Inter-American Court and Commission of Human Rights; 3. Similar Cases at International Level; 4. The denounce system and its failure; 5. The "Maternal Mortality" Factor; 5.1 Who are the victims?

In this chapter, the current situation on four states of Latin America in which obstetric violence has been recognised (even though in Mexico and Brazil it has been recognised only in some states) is analysed. As proved from the statistics reported, the violence is quite widespread throughout Latin America and affect many women of all social status even though, very often, women who are more likely to be victims are those from the most disadvantaged sectors of the population. In the second section, some cases concerning reproductive rights judged by the Inter-American Court and Commission of Human Rights are examined. They do not specifically address obstetric violence as there is still no definition of such violence at international level. Nevertheless, many similarities with the cases reported can be noticed and it is important to note how the different courts judged them. The same will be studied in the third section at international level. The fourth section tries to explain the main reasons why obstetric violence is not reported and the negative consequences this can cause. Lastly, a brief overview on the issue of maternal mortality explains the main causes that can led to it and who are the main victims at risk.

1. Obstetric violence in concrete

More than ten years have passed since the first law on obstetric violence has passed in Latin America. Since then, the countries which have recognised it have made many progress in trying to eradicate this violence from the maternal wards of their health facilities and the example of Venezuela has been inspiring for many countries, too which started to recognise and typify it in their national laws. Nevertheless, after the implementation of their national laws, the situation in Latin America is still critical. Indeed, many women have declared that they have experienced obstetric violence during the birth of their babies as reported by OVO (Observatorio Violencia Obstétrica) in Chile, by GIRE (Grupo de Información por la Reproducción Elegida) and many other associations and NGOs. Unfortunately, since obstetric violence is still not well known and due to the major problems of different nature the countries have, it is not always possible to rely on updated data on the current situation.

1.1 Venezuela. Ten years later

With respect to Venezuela, it is still difficult to obtain updated data and information. For sure, we know that many Venezuelan women who have the possibility, flee to Colombia to give birth because of the lack of medic supplies Venezuela is facing. As for the rest, there is no clear study of the incidence of obstetric violence in the population.

For sure we know that there are denounces and reports for cases of obstetric violence. For example, in 2014 a doctor was condemned to pay 250 unidades tributaries (about 2,620 euros).[348] The same year, two other doctors[349] had to pay a fine of 375 unidades tributarias - 47.625 Venezuelan Bolívares (the equivalent of 3,931 euros) responsible of taking no adequate and immediate care of a 32-year-old woman in a public hospital of Caracas in September 2009. The woman entered into the emergency room at 9 pm. Nevertheless, the C-section was performed only at 8 am of the following day when the foetus had already no vital signs. The two doctors received an additional sentence of temporary suspension from their duties. In the same way, two obstetricians were fined 132.894 Venezuelan Bolívares (the equivalent of 10,939 euros) because of their refusal, in November 2011, to attend a 35-year-old woman who arrived at the emergency room of a local hospital in the region of Zulia, west of Venezuela. The women entered the emergency room at 12.40 am but the C-section was performed only at 3 am of the following day causing the dead of the foetus. One of the last cases, in 2016, where a woman reported the case in Caracas[350] shows that Venezuela is complying with the law against obstetric violence.

Nevertheless, Venezuela has still much to do in the field of health care.[351] As reported by a report in 2015, "despite the progress in health, maternal mortality rates were persistently high, as was the rate of teenage pregnancies; abortion was heavily penalized which hampered the empowerment of women and could be the underlying cause of high maternal mortality rates." The same report indicated that the public health care system in Venezuela was not working: there was a lack of doctors, nurses, medical supplies and equipment. Venezuela had invested significant efforts in the protection of the family, including in protecting women from violence, but the implementation of the laws on violence against women was very weak."[352]

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[348] Tribunal Cuarto de Primera Instancia en funciones de Juicio de Portuguesa (Extensión Acarigua). Decisión nº PJ03320140000054, 5 March 2014.
Available at https://vlexvenezuela.com/vid/valderrama-ca-sar-gonza-lez-mara-nella-495841790

[349] Juzgado Primero de Primera Instancia en función de Juicio con competencia de delitos de Violencia contra la Mujer, 9 August 2010. Available at https://vlexvenezuela.com/vid/amc-guiillermo-onofre-brice-everling-301033750

[350] Corte de Apelaciones de Violencia contra la Mujer con competencia de reenvio de Caracas, decision No. 197-16. 19 August 2016. Available at https://vlexvenezuela.com/vid/acusado-luis-enrique-algara-647526897?_ga=2.139836151.553086162.1517960355-1284710703.1515946846

[351] Committee on Economic, Social and Cultural Rights. Report of Venezuela on the implementation of the provisions of the International Covenant on Economic, Social and Cultural Rights. 3 June 2015

[352] Ibid.

1.2 México and its Tribunal Simbólico

In México, statistics report that in the five-year period 2011-2016, the 33.4% of women suffered at least one type of abuse by those who attended her during her delivery. [353] Of the 3.7 million of women who had a cesarean, 10.3 percent were not informed of the reason why they needed it and 9.7 percent did not ask for permission to perform it. [354]

As a matter of fact, between 2009 and 2012 the National Human Rights Commission received 122 complaints related to obstetric violence[355] and the same Commission issued a comprehensive report of the situation in 2017 where it emphasised the importance of the issue.[356]

In Latin America, Mexico has done a lot in the fight against obstetric violence and the GIRE association is interested at national level in documenting cases of obstetric violence and helping victims going through the report since in Mexico there are several ways to access justice but without a precise method of reparation of damages. In case of violation of human rights, therefore, many different procedures are needed, something for which GIRE has been struggling for some time. For example, from January 2013 to August 2015, GIRE registered 16 cases, documented six cases and has litigated another six.[357]

Furthermore, the association GIRE has created in 2016 the Tribunal Simbólico. In 2016, 27 families, victim of obstetric violence and maternal death, gathered in Ciudad de México to share their experience in front of a panel composed by six internationally recognized judges, experts in healht and human rights. The judges prepared a report and issued recommendations to the state on how to prevent the violation of human rights and directed these recommendations to the three powers of the state. Obviously, being a symbolic tribunal of an association, its recommendations are not legally binding. Nevertheless they are a source of great importance for the governments of the states that receive it and in many cases, improvements to the health system and denunciation have been made.

One of the key cases in the Tribunal Simbolico, was the case of Irma, a mazateco woman of scarce economic resources.[358] At the beginning of October, 2013 she went to the Centro de Salud de San Felipe Jalapa de Díaz, Oaxaca as she was feeling ill but the nurse told her to go out for a walk as she

[353] INEGI (Instituto Nacional de Estadistíca y Geografía).)2016). ENDIREH 2016. México, pp 16-18
[354] Ibid.
[355] International Day of Action for Women's Health. Retrieved 02 February 2018, from http://www.may28.org/obstetric-violence/
[356] Comisión Nacional de Los Derechos Humanos. Recomendación General No. 31/2017 sobre la Violencia Obstétrica en el Sistema Nacional de Salud. Mexico D.F. July 2017. Available at http://www.cndh.org.mx/sites/all/doc/Recomendaciones/generales/RecGral_031.pdf
[357] GIRE, Fundación Angélica Fuente. (November 2015). Obstetric Violence. A Human Rights Approach. México, p. 78. Retrieved from https://gire.org.mx/en/wp-content/uploads/sites/2/2015/11/ObstetricViolenceReport.pdf
[358] Full details of the case Irma López Aurelio in Informa GIRE 2015, p. 118-121

was not ready to give birth yet. As soon as she left the hospital, Irma gave birth in the hospital court, without any help or medical assistance. A photo of Irma giving birth to her child in front of the hospital, was posted on internet and went virale. After the complaint, the CNDH issued a recommendation[359] to the state of Oaxaca, held responsible for the facts and the lack of medical assistance as the health facility had violated the human rights of Irma and the new-born. In the recommendation further, the CNDH recommends the establishment of training of the whole health personnel about human rights as well as a certification, with the aim to bring an adequate and professional health service to pregnant women.

Following the case, the government of Oaxaca recognised its responsibility and committed with the recommendations of the CNDH and to repair the economic damages to Irma (which actually did in March 2014) as well as the insittution paid its public apology for what happened. Furthermore, the state of Oaxaca committed to construct 50 delivery rooms. Unfortunately, not every point of the reccomendation has been put in practice. At the end of 2015 the works for the delivery rooms had not started yet due to lack of federal funds and notwithstanding the commitment of the state, there is still a lack of medical supplies, facilities and skilled health personnel in the health facilities. The Mexican state of Oaxaca is pehaps the state which count with more cases of obstetric violence in the whole country. According to the report ¿Dónde está la esperanza?[360] issued in November 2016, 80% of the Indigenous pregnant women have been victim of obstetric violence.

The second key case of the tribunal Simbolico and perhaps the case that has had more media coverage is the case of Liliana. The case of Liliana shows how all pregnant women can be victims of obstetric violence, even if they have a high education. During a caesarean, despite the expressed will of a vaginal birth (as assured by the first doctor who had visited the woman), Liliana lost consciousness. When she woke up, she was suffering from severe pain. In spite of this, she was discharge and sent home but the pain was worsening and after being hospitalized and ignored again, she decided to enter a private clinic. There, after six days of exams and three surgeries, the doctors found out that her bladder and her uterus had been perforated during the caesarea. For this reason, Liliana lost then the capability to have more children as she had planned.

These two cases, perhaps the most emblematic of all which have been by the association GIRE, witness the negative attitude of some maternal heatlh services in Mexico and not only.These same patterns of conduct are found in many maternity wards all around the world.

The case of Irma was also presented before the Inter-American Commision of Humanr Rights in March 2014 togheter with the recocomnedation issued by the CNDH as well as togheter with many

[359] Comisión Nacional de los Derechos Humanos. Recomendación 1/2014. Mexico D.F. 2014. Available at http://www.cndh.org.mx/sites/all/doc/Recomendaciones/2014/Rec_2014_001.pdf

[360] Consorcio para el Diálogo Parlamentario y la Equidad Oaxaca. (November 2016), ¿Dónde está la esperanza? Miradas sobre la violencia feminicida y los feminicidios en Oaxaca durante el gobierno de Gabino Cué (2010-2016), p.73

other cases. These cases became well known in Mexico for the impactant role they assumed in the media. Thanks to this, the phenomenon of obstetric violence has began to be known by more and more women all around Mexico who recognise themselves as victims and thus begin to report the mistreatments they received during their pregnancy and labour.

1.3 Situation in Argentina

According to an investigation carried out by the feminist movement Ni Una Menos, the most important feminist organisation in Argentina and one of the biggest in Latin America, and as reported by its co-founder on the various types of violence against women in Argentina[361], the women who have been victims of at least one situation of obstetric violence are 77% of the whole interviewed women. This data reaches its highest peaks in certain provinces of the country, for example in the northern region of Tucumán (98%) and in the south region of Tierra del Fuego where 97% of pregnant women reported to have suffered at least one situation as defined as obstetric violence during their labours. Some other provinces of Argentina has relly high porcentages of victims like Misiones, San Juan and Mendoza (92%), La Pampa (95%).[362]

Almost half of the women was treated as if they did not understand the processes they were going to be undergone. Almost the totality of women (95%) said that they had found themselves in a situation of report. Nevertheless, only 30% tried to complain. In 25% of these cases, the complaint was not accepted. An important date is that about one woman in three does not tell anyone what she went through. This leads to a negative effect because, if no one denounces and stops the practice of practicing obstetric violence in health facilities, the abuse as normal routine will follow.[363]

Not only Venezuela, also Argentina is putting in practice its national law about obstetric. In 2014, a judge condemned an obstetrician to 2 years of prison for medical negligence. In fact, in March 2007 he unnecessarily delayed the birth of a foetus who presented foetal bradycardia (a reduction of heart rate below the normal value) causing permanent damages to the foetus' neurologic functions. This results in an inability to live a normal life.[364]

In June 2017 the first case of obstetric violence in Argentina became famous.

[361] Ni una Menos. (November 2016). 1° Índice Nacional De Violencia Machista. November 2016. Available at https://drive.google.com/file/d/0BzQUku9vPMaLMUFaMVphLWJzMG8/view

[362] For all data according to the province Resumen General Del Índice Nacional De Violencia Machista. Available at http://contalaviolenciamachista.com/resumen.html

[363] Ibid. at 357, p. conclusiones

[364] Fiscales.gob.ar. Violencia obstétrica: condenaron a un médico a dos años de prisión. Available at https://www.fiscales.gob.ar/fiscalias/violencia-obstetrica-condenaron-a-un-medico-a-dos-anos-de-prision/

The victim is an Argentine actress, Agustina Petrella. [365] During her first birth, she was not satisfied with the conditions. Although her obstetrician was an eminence in the hospital, Petrella suspected that doctors had accelerated the delivery during the visit and for this reason she had to undergo to an emergency caesarians. For the second child, about one year later, she decided then to go to a clinic where he had planned a delivery plan with precise indications to follow in order to have a humanised birth. The plan was not respected and as soon as she left the clinic, Petrella filed a complaint. [366] Whereas before there were only cases in which obstetric violence was mentioned in the case of the death of a newborn or of the mother, this is the first exclusive case concerning obstetric violence reported in Argentina.

1.4 In Brazil

Brazil presents a peculiar situation since just one State has recognised and criminlised obstetric violence in its state law. Nevertheless,one in four women in Brazil is victim of such violence. It is necessary to remind that Brzil is one of the countries with the highest caesarean rates in the world (82% for those with private insurance and more than 50% for those without).[367]

A case in Brazil illustrates how women's human rights are disregarded in the name of the unborn child. A 29-year-old mother[368] who previously had two Caesarean deliveries was preparing to give birth to the third child vaginally – Vaginal Birth After Caesarean (VBAC). Despite living in a country with one of the highest rate of caesarian, she felt the earlier Caesarean sections were unnecessary. In her case, doctors had obtained a court order allowing the hospital to perform a caesarean. Instead of delivering her baby on her terms, the woman was taken from her home, forcibly anaesthetized and operated without consent.

Brazil has also a great inequality in the health services according to which sector of the population they are addressed to. For example, one of the indicators used to measure MDGs is the proportion of births that are attended by skilled health personnel. Brazil was a country that is classified as having achieved success on this indicator. However, the high overall coverage for skilled attendance is not enjoyed equally by all Brazilian women. A 2007 study showed that low-income Brazilian women

[365] Gisele Sousa Dias. Acá no estamos para cumplir los caprichitos de los padres. La historia detrás del primer juicio por violencia obstétrica del país. 28 June 2017 Retrieved 30 January 2018, from https://www.infobae.com/sociedad/2017/06/28/aca-no-estamos-para-cumplir-los-caprichitos-de-los-padres-la-historia-detras-del-primer-juicio-por-violencia-obstetrica-del-pais/

[366] File of the denounce can be found at http://perlaprigoshin.com.ar/wp-content/uploads/2016/02/Res-02-2016-Petrella.pdf

[367] Organização Artemis (ONG Contra Violência Doméstica e Obstétrica). Violência Obstétrica. Retrieved 29 January 2018, from https://www.artemis.org.br/violencia-obstetrica

[368] Report of the case by organização Artemis available at https://www.elpartoesnuestro.es/sites/default/files/public/blog/20140407CasoBrazil/denuncia_adelir-torresrs-sdh.pdf

were greater than twenty times more likely not to be attended by skilled personnel during delivery than rich women.[369]

2. The Inter-American Court and Commission of Human Rights

Reproductive rights throughout the Americas can rely on the inter-American system for the protection of human rights which includes the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. The Commission was created in 1959 by the Organisation of American States due to the need of creating an efficient mechanism for the protection of human rights. Eight years later the OAS strengthened the role of the Commission designating it as its principal forum about human rights.[370] In the Part II of the American Convention on Human Rights concerning the Means of Protection the two organs are entitled to have competence with respect to matters relating to the fulfilment of the commitments made by the States Parties to the convention. The organisation, functions, competences and procedures of the Commission are regulated in Chapter VII of the Convention whilst the Chapter VIII regulates the same for the Court.

The Inter-American system for the protection of human rights has created since its foundation, an important body of charters and conventions on human rights.

As a result of the fact that there is no recognition at international level, there are no cases judged by the Inter-American Court and Commission of Human Rights concerning obstetric violence, yet. But in spite of that, there are some important cases which are milestone in the jurisprudence of reproductive health which can act as an important corpus of legal records and that set some important interpretations about the rights of pregnant women and can support the thesis of obstetric violence as a violation of human rights and as a type more of violence against women, institutional and intersectoral violence. [371]

The first case relevant to reproductive rights is the case Penal Miguel Castro Castro Vs. Perú.[372] The facts took place in 1992 some days after the president of Perú at the time, Alberto Fujimori dissolved the Congress, suspended the Constitutional, removed several judges from the Supreme Court of Justice[373] and set a "emergency government for the national reconstruction" with the aim of fight the

[369] Center for Reproductive Rights. (2014). From Risk to Rights. Realizing States' Obligations to Prevent and Address Maternal Mortality, p. 20

[370] OAS, Charter of The Organization of American States. 30 April 1948, Article 53

[371] Inter-American Court of Human Rights. (2017). Cuadernillo de Jurisprudencia de la Corte Interamericana de Derechos Humanos No. 4.

[372] Miguel Castro-Castro Prison v. Peru (Inter-American Court of Human Rights 25 November 2006). Available at http://www.corteidh.or.cr/docs/casos/articulos/seriec_160_ing.pdf

[373] Gardini G.L. (2012). Latin America in the 21st Century. Nations, Regionalism, Globalization. London: Zed Books, p. 43

guerrilla of Shining Path (Sendero Luminoso)[374], the Peruvian revolutionary movement, inspired in Mao aimed to establish a socialist government in Peru. This internal fight Peruvian government against the terrorist organisation Shining Path had begun in the 80s, a turbulent period for the country. In doing so, the country experienced an initial excellent economic result, thanks to the defeat of the Sendero Luminoso organisation but then the economy slowed down and Fujimori lost credit and power until he had to resign in 2001.[375]

In the vision of the fight against the organisation, in April 1992, Peruvian National Police and Peruvian military attacked the prison of Miguel Castro Castro and injured and killed many Sendero Luminoso members. The prison in San Juan de Lurigancho, east of the capital city of Lima, held, at the time, many convicted or accused of terrorism or treason and suspected of being members of the terrorist organisation. Among the inhuman treatments prisoners received by police and state officers, the final judgment of November 2006, mentioned "lack of attention to women's physiological needs when they were denied materials of personal hygiene […], lack of attention to pre- and postnatal health needs [...]. The damages and suffering experimented by women in general and especially the pregnant women and by the inmates that were mothers were especially gross."[376] At the moment of the attack in fact, there were three pregnant women in the prison[377] who suffered from extreme pre-natal violence. Among the violence they suffered it is reported they were also beaten to their wombs."[378]

The state of Perú was found responsible for the violation of the Right to Humane Treatment according to the Article 5 of the American Convention in relation to Article 1(1) of the same, and in Connection to Articles 1, 6, and 8 of the Inter-American Convention to Prevent and Punish Torture since prisoners were deprived of food, water, electricity, and medical attention for the whole period of the attack (four days). They suffered psychological torture for this reason and pregnant prisoners suffered doubly: for their own lives and the lives of their children.[379]

It is considered as inhumane treatment also "the type of insults directed to [the women], the way in which they were beaten, and the prison regimen that denied them access to artefacts of feminine care, gynaecological attention, [and] maternity rights"[380]

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[374] Paz J.J., Cepeda M. (2002). Golpe y contragolpe: la "Rebelión de Quito" del 21 de enero de 2000. Quito, Ecuador, p. 66

[375] Ibid. at 373

[376] Ibid at 372, para 319

[377] The three detainees who were pregnant were respectively, 7, 5, and 8 months pregnant at the time of the attack. The inmates Eva Challco and Sabina Quispe gave birth when they were, respectively, in the prisons of Cachiche and Chorrillos, and they did not receive medical attention until they were taken to the hospital for their labour. The inmate Sabina Quispe did not receive post-partum medical attention. (para 61)

[378] Ibid. para 260(z) p. 107

[379] Loyola Law School. (2006). Miguel Castro Castro Prison v. Peru. Retrieved from https://iachr.lls.edu/cases/miguel-castro-castro-prison-v-peru

[380] Ibid para 260(r), p. 105

In the same way it inflicted brutal physical violence and serious psychological violence "intentional denial of adequate pre- and post-natal medical attention to pregnant women, as well as of basic condition within the prison that would respect the human dignity of women"[381]. For what concern pregnant women "who lived through the attack, experimented an additional psychological suffering, since besides having seen their own physical integrity injured, they had feelings on anguish, despair, and fear for the lives of their children"[382] thus the acts of violence had a greater effect on them.[383]

Furthermore, the state did not guarantee adequate healthcare to these women. As a matter of fact, the final judgment also condemned the state for the results of a confinement for those detainees who were mothers stating that "[s]everal international organizations have made emphasis on the States' obligation to take into consideration the special attention that must be offered to women due to maternity."[384]

For example, one of the victims was seven month pregnant at the time of the attack and "she was forced to lie on a piece of land, along with other women "that were bleeding and wet", where she was kicked and obliged to lie face down for hours, despite her pregnancy."[385] Another alledged victim witnessed that medical assistance for the wounded and for pregnant inmates were denied.[386] For what concern the pregnant treatment women received, the Court stated that "female detainees must be supervised and checked by female officer and pregnant and nursing women must be offered special conditions during their detention."[387]

In the end, the case of Miguel Castro Castro Prison resulted in the State responsible also for the violation of the right to life according to the Article 4 of the American Convention in relation to article 1(1) of the same as response of the death of 41 prisoners[388] because the inmates were not in riot and therefore the fact that the state attacked them was not justified. Furthermore, the autopsy revealed that the shots fired by the police agents during the attack to the prison had not the purpose to immobilize or persuade the inmates from fighting back, but instead cause an irreparable damage to the lives of people.[389] For this reason, the State and its agents have failed in their role of protecting lives.[390]

[381] Ibdi para 260(u), p. 106
[382] Inmates were Mrs. Eva Challco, who approximately one month after the attack had her son Said Gabriel Challco Hurtado; Vicenta Genua López, who was five months pregnant; and Sabina Quispe Rojas, who was eight months pregnant as identified in para. 197(57)
[383] Ibid. para 293, p. 113
[384] Ibid. para 330, p. 115
[385] Ibid. testimony 6, p. 34
[386] Ibid. para 7, p. 41
[387] Ibid at 385
[388] Ibid para 228, p. 88
[389] Ibid para 243
[390] Ibid para 239

This violation was even more severe as a consequence of the fact that many of the victims were women.[391] The State was also in violation of Article 3 of the Convention Belem do Para which rules the right to be exempt of violence in the public and private sphere as well as the protection of other basic rights including life.[392]

In this sense, besides the protection granted by Article 5 of the American Convention, it is necessary to point out that Article 7 of the Convention of Belem do Pará expressly states that the States must ensure that the state authorities and agents abstain from any action or practice of violence against women."[393] This breach was worse regarding those inmates who were injured and the women who were pregnant[394] also because as in the case of the prisoner Eva Challco, Sadi, her son, "should have been considered present in pavilion 1A, since he was about to be born and has been a direct victim of the entire attack as a person since he was physically there within Eva's womb."[395]

In addition to that, it has stated that female detainees must be supervised and checked by female officer and pregnant and nursing women must be offered special conditions during their detention.[396]

The Miguel Castro Castro Prison v. Peru is important because it is also the first case in which the Court has enforced the Convention Belem do Para for the human treatment women received even though when the facts happened, Perú was not part of the convention, yet.

From this case, therefore, we can deduce that the state committed itself and thus has the duty to guarantee, in all situations, adequate health care to pregnant women as well as a human treatment and it is responsible to all violation of standard of human treatment when it fails to provide adequate situations and procedures for pregnant women.

In the last decades, many associations and NGOs have presented cases to the Commission to for the violation of reproductive rights throughout Latina America. An interesting case for our field of study is the case of María Mamérita Mestanza Chavez v. Perú[397] which resulted in a condemn for the state of Perú for forced sterilization that ultimately caused death to the woman. CLADEM, the Office for the Defense of the Rights of Women (DEMUS), and the Association for Human Rights (APRODEH) presented the case before the Commission in 1999. The Center for Reproductive Rights and CEJIL joined them one year later.

[391] Ibid para 228(p), p. 90
[392] Ibid para 228(p), p. 90
[393] Ibid para 292, p. 112-113
[394] Ibid para 300
[395] Ibid para 229(g), p. 92
[396] Ibid para 303
[397] María Mamérita Mestanza Chávez v. Perú (Inter-American Commission on Human Rights 22 October 2003). Available at http://www.cidh.org/annualrep/2003eng/peru.12191.htm

Maria Mamerita Mestanza Chavez was a young rural woman from the region of Cajamarca in Perú. She was threatened to be reported to the police if she did not accept to undergo surgical sterilisation (she had seven children). Medical staff alleged that the government had approved a law according to which people with more than five children have to pay a fine and go to prison. She eventually accepted and after the surgical intervention performed without reading her the form even knowing she was illiterate, she was discharge despite severe complications. Her conditions kept worsening and her partner sought for medical assistance which never arrived due to the fact that doctors minimised the pain as post-surgery effects. The woman eventually died nine days after the surgery. The case of Maria Mamerita is one of the thousands concerning forced sterilisation that Peruvian government put into practice del Peru' as a means for rapidly altering the reproductive behaviour of the population, especially poor, Indigenous, and rural women.[398]

The case was declared admissible, in relation to the violations alleged of Articles 1, 4, 5, and 24 of the American Convention, and Article 7 of the Convention of Belém do Pará[399] and the Commission found the state of Perú as responsible of violation of the rights to health and free and informed consent as agents of the state put her physical health at risk, by performing unnecessary surgery without her informed consent and without first performing a medical exam. Mestanza was also treated in a negligent, cruel, inhuman, and degrading manner by Peruvian health services employees when she was refused necessary post-operative care.[400]

It is possible to apply the concept of intersectionality as seen in chapter 3, section 3. As a matter of fact, Maria Mamerita Mestanza was sterilised not only for being a woman but above all for being indigenous, poor and from a rural area.

In the friendly settlement the petitioners claimed for a violation to the articles 12 and 14 of the Convention on the Elimination of All Forms of Discrimination Against Women about discrimination against women in the field of health care and the right of rural women.

The state in this case is held responsible for interference in the private life of women in case of arbitrary decisions on their reproductive sphere. The state should in any case guarantee an autonomous and informed decision with respect to this area. This guarantee applies also and above all to the indigenous women or from the poorer areas of the country which are the main victims of such violence and discrimination.

[398] Inter-American Court of Human Rights, Report Nº 71/03 Petition 12.191 Friendly Settlement María Mamérita Mestanza Chávez. Perú. 22 October 2003, para 9

[399] María Mamérita Mestanza Chavez v. Peru, Case 12.191, Report No. 66/00, OEA/Ser.L/V/II.111 Doc. 20 rev. at 350 (2000).

[400] Center for Reproductive Rights. (October 2002). Reproductive Rights in the Inter-American System for the Promotion and Protection of Human Rights

When it comes to the responsibility of the state in the case of violence against violence against women, it is also important to remember the case Campo Algonodero (Cotton Field) v. México[401]. The case concerns the disappearance of three young women in the city of Ciudad Juarez. Located on the Mexican border with the United States, Ciudad Juarez has become a city where the indices of violence and killings generate concern not only in the Mexican state, but worldwide. This city, like others bordering the United States, suffer the particular problem of having the system of work in *maquilas*, companies where products are manufactured to be sold abroad, mainly in the United States, thanks to the Free Trade Agreement. The continuous competition to maintain accessible market prices, generates that the conditions of work and wages are low, being mainly women who occupy these jobs. The three girls who disappeared, were found dead a few months later in a nearby cotton field. Women presented signs of sexual violence. Despite the reports of disappearance made by the families of the three girls, the investigations for the investigation of the perpetrator never began and that is precisely the reason why the state was found responsible.[402] It is in fact recognized that the girls were victims of gender based violence in violation of Obligation not to discriminate (Articles 1(1)) and of right to Life (Article 4) of the American Convention of Human Rights since "the State "did not adopt reasonable measures to protect the life and prevent the murders" of the victims "although it was aware of the imminent risk that they would be murdered, as they had been reported as missing, as of the date of the facts."[403] with the aggravating circumstance of the young age of the victims (Article 19 Rights of the Child to protection as required by their condition).

Of course, the State could not prevent the disappearance of the three girls in this case but without any doubt it was "aware of the situation of risk for women in Ciudad Juárez particularly young women from humble backgrounds" presented[404] and should have implemented a general policy accordingly to the problem. The Mexican CNDH had in fact previously warned the state of the pattern of violence against women in Ciudad Juárez.

After their disappearance, the State should have assumed the danger the three women were facing and should have acted without any delay in order to prevent a more negative outcome for the girls. The officials in charge did not act with the required due diligence to prevent the death and abuse[405] of the three girls therefore the State violated their right to Humane Treatment (Articles 5) and to personal liberty (Article 7) as in the Convention of Human Rights since it did not protect them after their disappearance trying to do everything possible to bring them home. In both situations, the state

[401] González et al. ("Cotton Field") v. Mexico (Inter-American Commission on Human Rights 16 November 2009). Available at http://www.corteidh.or.cr/docs/casos/articulos/seriec_205_esp.pdf
[402] Ibid para 285
[403] Ibid para 249
[404] Ibid. para 282
[405] Ibid para 284

violated also the Article 7 on the States' obligation to prevent, punish and eradicate violence against women of the Convention of Belem do Para for the same failures.

Finally, the state is held responsible for an ineffective investigation for the murders: there have been irregularities during the investigations, the discovery of the bodies, the custody of the crime scene, the collection and handling of evidence, and later during the autopsies, the identification and the return of the victims' remains without any positive identification.[406] In this way the state violated the girls' Right to a Fair Trial (Article 8) and the Right to Judicial Protection (Article 25).

Indeed, the state has the important task to "adopt comprehensive measures to comply with due diligence in cases of violence against women. In particular, they should have an appropriate legal framework for protection that is enforced effectively, and prevention policies and practices that allow effective measures to be taken in response to the respective complaints."[407] The state is therefore responsible for the safeguard of security of its people.

This case is important because it underlines the commitment that the state assumes to preserve women from any type of violence that can happen within its borders and, in case that happens, the obligation to investigate and ensure justice to the victim of such violence or to their family.

For what concerns the difficulty to report and the responsibility of the State to guarantee the reporting of any violence within its territory, an important case is the case of Valentina Rosendo Cantú v. México[408] where a reference is made to the difficulties of an indigenous woman to achieve effective methods of denouncement. The case is about an Indigenous girl who was raped and tortured by a military. The Commission declared the petition of Mrs. Rosendo Cantú admissible and the State was held responsible for the violation of the right to humane treatment and not to be subjected to torture or to cruel, inhuman, or degrading punishment or treatment due to the violation Mrs. Rosendo had been victim of (Article 5.2), to honour respected and dignity recognised and their protection (Article 11) in relation to the right to free and full exercise all rights and freedoms of the convention, without any discrimination (Article 1). As well as the violation to prevent and punish torture (Article 1) according to the definition of torture given in Article 2 taking effective measures within the state's jurisdiction (Article 6) of the InterAmerican Convention to Prevent and Punish Torture and finally, of Article 7(a) of the InterAmerican Convention on the Prevention, Punishment and Eradication of Violence against Women, which states that authorities, officials, personnel, agents, and institutions of the state must refrain from engaging in any act or practice of violence against women. One of the

[406] Ibid para 296-332
[407] Ibid para 258
[408] Rosendo Cantú et al. v. México (Inter-American Court of Human Rights 31 August 2010).

most important aspects resulting from the case is the difficulties encountered by indigenous people, particularly women, to obtain access to justice and health care.[409]

In fact, when she was victim of the rape, Mrs. Cantú lived in an isolated mountainous area and was obliged to walk eight "hours to receive medical care for the physical assault she suffered and then to file a complaint of rape before various authorities that spoke a language she did not understand. She also knew that these facts would likely have negative repercussions in her social and cultural environment, such as the possible rejection by her community."[410] In this case the State failed to guarantee an effective and adequate access to justice and to medical care to the victim due also to the fact that there were no health facilities and denounce system in the area where the girl came from which it supposes a lack of commitment by the State which should assure services within its territory.

The Court was very interested in cases of indigenous community and their rights. Some extracts of the following cases dealing with the rights of Indigenous communities in Paraguay are useful for founding precedents in the case of violation of rights against large sections of the population of Latin America as can be indigenous people and above all women belonging to these communities.

The first case to analyse is the case Indigenous Community Yakye Axa v. Paraguay[411]. The Yakye Axa are an Indigenous community who lived in the region of Chaco in Paraguay. The case refers principally to the property right of some ancestral lands by the indigenous community. Nevertheless, some important clarifications are made by Court regarding the health of pregnant women.The commission found the case to be admissible and the state responsible of the violation of the rights to Fair Trial and to Judicial Protection Articles 8 and 2 of the American Convention on Human Rights in combination with the duty of the State to respect the rights and freedoms recognized in the Convention without any discrimination (Articles 1(1)) as well as the duty of the state to undertake legislative or other measures as may be necessary to give effect to these rights or freedoms (Article 2 of that same Convention), the Right to Property embodied in Article 21 and the Right to Life embodied in Article 4(1) regarding the conditions that affected the possibility of the community of having a decent life. Violation of life which includes not only the right not to be deprived of live but also the right not to be denied the conditions required to ensure a decent existence"[412] In fact, embedded in the concept of decent life, there is the responsibility for the provision of "regular medical care and appropriate medicine to protect the health of all individuals, especially children, the elderly and pregnant women, including medicine and adequate treatment to deworm all the members of the

[409] Ibid para 2
[410] Ibid para 93
[411] Yakye Axa Indigenous Community v. Paraguay (Inter-American Court of Human Rights 17 June 2005). Avaialbale at http://www.corteidh.or.cr/docs/casos/articulos/seriec_125_ing.pdf
[412] Ibid para 157

Community" as well as the "delivery of sufficient food, with the appropriate variety and quality, for the members of the Community to have minimum conditions for a decent life; to provide latrines or any other type of appropriate sanitary facilities for effective and salubrious biological waste management in the Community; and to provide sufficient bilingual material for the educational requirements of the students at the school in the Community's current settlement."[413]

The same decision is also taken for the case of Sawhoyamaxa Indigenous Community in Paraguay[414] which refers to the possession of ancestral lands as well. The commission found a violation of Article 8 (Right to a Fair Trial) and Right to Judicial Protection (Article 25) given the long period of time for the Community to be heard (more than four years) and because of the administrative proceedings which had been ineffective for different reasons[415] violating then the community's Right to Property (Article 21).[416] Most important, the state violated also the right which Prohibits an Arbitrary Deprivation of Life Article 4(1) because the State did know the poor conditions the Community lived in, nevertheless it did not do anything. Moreover, the violation of this last rights enshrines the difficulties the members had to face to access health care services[417] due to the distance from the community and, above all, the great cost of money for being admitted and the medicaments. This expense caused the death of many children, including new-borns and violated Article 19 of the American Convention on the rights of the child.[418] As a matter of fact, the State was responsible for not adopting special measures based on the best interest of the child. As stated by the Court, these measures cannot be separated by the likewise vulnerable situation of the pregnant women in fact, the Court also underlines the "vulnerable situation of the pregnant women of the Community"[419] and the fact that the State must also "devote special attention and care to protect this group and must adopt special measures to secure women, especially during pregnancy, delivery and lactation, access to adequate medical care services."[420]

Finally, the state is responsible for the treatment of pregnant women also in the case of the Indigenous Community of Xákmok Kásek.[421] The case concerns a request from the 80s for the possession of their ancestral lands in the region of Chaco (Paraguay) which had been taken away during the XIX and

[413] Ibid. para 221
[414] Sawhoyamaxa Indigenous Community v. Paraguay (Inter-American Court of Human Rights 29 March 2006). Available at http://www.corteidh.or.cr/docs/casos/articulos/seriec_146_ing.pdf
[415] Ibid. para 104
[416] Ibid. para 144
[417] Ibid. para 170-175
[418] Ibid. para 177
[419] Ibid. para 177
[420] Ibid.
[421] Xákmok Kásek Indigenous Community v. Paraguay (Inter-American Commission on Human Rights 24 August 2010), para 233 Available at http://www.corteidh.or.cr/docs/casos/articulos/seriec_214_ing.pdf

early XX centuries. "Due to the separation from their lands, the number of deaths in the Community, and the poor living conditions of the estancias, members of the Community suffered for years while waiting for the State to return its lands."[422]

The case was considered admissible and the state was found in violation of the rights to a hearing within reasonable time by a competent and independent tribunal as stated in Articles 8(1) of the American Convention as it did not provide an effective or appropriate remedy as well as the violation of the right of recourse before a competent court as in Article 25.1 of the same Convention since the State did not provide sufficient inspections and the remedy was ineffective. For this reason, the community did not have their lands back which resulted in a violation by the state of the community's right to use and Enjoyment of Property (21.1) in relation to Articles 1(1) and 2 of the Convention. Furthermore, the state was held responsible for the violation of Article 4(1) concerning the prohibition of Arbitrary Deprivation of Life[423] where the right to life has to be understood in a more comprehensive way. In fact, it includes also the right to access the conditions for a decent life, conditions which the State failed to provide to the community in form of adequate health service, among other services.

In fact, these shortcomings had caused, among other issues, a situation of "extreme poverty and [a] lack of adequate medical care for pregnant women or women who have recently given birth [which resulted in] high maternal mortality and morbidity."[424]

The state is therefore held responsible for the situation suffered by the Community of Xákmok Kásek and it is called to "design appropriate health-care policies that permit assistance to be provided by personnel who are adequately trained to attend to births, policies to prevent maternal mortality with adequate pre-natal and post-partum care, and legal and administrative instruments for health-care policies that permit cases of maternal mortality to be documented adequately. All this is because pregnant women require special measures of protection."[425] The court then asks for compensation from the state to take a series of measures among which, the administration of "specialized medical care for pregnant women, both pre- and post-natal and during the first months of the baby's life."[426]

Especially in this last case, the State was found responsible also for the death of a 38-year-old woman following some complicacies which arouse in response at her birth with no medical attention.[427] In fact, States must provide adequate health policies that offer assistance with adequately trained personnel for the attention of births, policies for the prevention of maternal mortality through prenatal

[422] Ibid para 243
[423] Ibid para 217
[424] Ibid para 233
[425] Ibid
[426] Ibid para 301(c)
[427] Ibid para 232

and post-partum check-ups as necessary as pregnant women need measures of especial protection.[428] In this regard, the state is responsible of the violation of Article 4.1 of the American Convention in relation of Article 1.1 as it didn't adopt special measures to prevent the risk to the right to life. "States must design appropriate health-care policies that permit assistance to be provided by personnel who are adequately trained to attend to births, policies to prevent maternal mortality with adequate prenatal and post-partum care, and legal and administrative instruments for healthcare policies that permit cases of maternal mortality to be documented adequately".[429]The state is also responsible in this case for a failure to cover the territory as regards the health service. The closest health service was situated 75 km far away the community and has no vehicle in case of emergency. In such cases, the health facilities who can deal with emergency is situated 400 kilometres away.[430]

From the analysis of the rights and the cases, many data which may be useful for the application to obstetric violence emerged.

For example, in the case Castro Castro v. Peru, the State is held responsibility for the actions (among which tortures and other inhumane treatments) of its agents and for not guaranteeing gynaecological attention, and maternity rights such as adequate pre- and post-natal medical attention to pregnant women. In the case of Maria Mamerita Mestanza v. Peru, the same State was held responsible for an unnecessary procedure without having previously informed the victim and thus having obtained her consent. Furthermore, the state provided the victim with false information to convince her to undergo the sterilisation and after the procedure, it discharged her without any post-surgery care that eventually resulted in the death of the woman. In the case of Cotton Field v. Mexico, the State failed to guarantee women a life free of violence as well as it failed to guarantee an immediate and effective access to justice. It was then, responsible for the acts and omission of third parties. In this case, as in the case of the Indigenous communities of Yakye Axa, Sawhoyamaxa and Xákmok Kásek, the sentence is more severe because the states were aware of the difficult situation of the women in Ciudad Suarez and in the region of Chaco. That has been proved also in the case of Rosendo Cantu v. Mexico who, in addition to the difficulties in access to justice, had also no medical health facilities near her.

Then, the Commission and the Court regulate that effective pre- and post- natal medical attention care should be guarantee to all women, regardless their conditions (also for what concerns cases of women deprived of their liberty or from a more vulnerable sector of society like Indigenous women or poor, rural women). With regard to pregnant indigenous women, the cases judged by the Inter-American Court of Human Rights demonstrate how many cases of violation of rights to indigenous women there

[428] Ibid para 233
[429] Ibid para 234
[430] Ibid para 203

are. The important fact highlighted is the responsibility of the state in taking care of the most vulnerable sectors of population and above all, of the pregnant women, providing not only health services and goods but also a whole series of other factors for the full enjoyment of their rights.
The adequate provision of maternal care includes goods and services available within the territory, skilled assistance during any stage of the pregnancy and labour as well as adequate pre- and post-partum care as stated in the judgments of the Inter-American System of Human Rights in the cases of the Indigenous communities of Yakye Axa, Sawhoyamaxa and Xákmok Kásekv in Paraguay which all refer to the duty of the state of guarantying the access to health goods and services to all sectors of population, including the most difficult and far to reach communities. It must also include the provision of sufficient and adequate information in the reproductive field in order for a free and informed consent, a right which should always be guaranteed by the State.

3. Similar cases at international level

UN Treaty Monitoring Bodies were created to ensure governments' compliance with the treaties they refer to. All the six most relevant UN treaties on human rights have its own committee whose aim is to monitor governments compliance with the treaties, periodically report the efforts made and they have the authority to issue general recommendations and comments, too. Even though these documents are not binding, they provide an important source of interpretation of the articles of the treaties.[431] Three of the most important cases concerning cases similar of obstetric violence were filed before a UN Treaty Monitoring Body: L.C. v. Perú and the case Alyne da Silva Pimentel v. Brazil before the Committee on the Elimination of Discrimination against Women and K.L. v. Perú before the Human Rights Committee.

L.C. [432] was a young girl who became pregnant after being raped. In depression, she decided to take her life jumping off the roof of a building but she survived. However, she reported a severe spinal injury which needed an emergency surgery. Being pregnant, doctors refused to perform the surgery and accepted only some weeks after L.C. had a spontaneous miscarriage. In the meantime, a legal therapeutic abortion was denied. The surgery was then performed almost three and a half months after it had been decided that it was necessary[433] and four more months had to pass before the physical rehabilitation and psychological or psychiatric help she required began.[434]

[431] Center for Reproductive Rights. (January 2008). Family Planning is a Human Right Government Duties to Ensure Access to Contraceptive Services and Information
[432] UN Committee on the Elimination of Discrimination against Women. L.C. v. Perú. 18 June 2009
[433] Ibid para 2.10
[434] Ibid

Being the surgery performed too late, it resulted in a complete useless procedure which is why L.C. is now quadriplegic. Furthermore, the great expense due to L.C. medicine and cares made her family going through many difficulties as her brothers had to left school to go working whilst her mother cannot due to the fact that she had to take care of her daughter 24/7.

The Center for Reproductive Rights and Promsex, two non-profit organisations, filed the case before the Committee on the Elimination of Discrimination against Women in 2009.

The Committee found the State of Perú responsible of the violation of Article 2(c) and (f), the right of a protection against discrimination, 3, 5 (freedom from wrongful gender stereotyping) as the timely access to necessary medical treatment was made conditional on carrying to term an unwanted pregnancy, which fulfils the stereotype of placing L. C.'s reproductive function above her right to health, life and a life of dignity. In fact, the stereotype that L.C. had to be a mother overcome her personal rights. Furthermore, the state was responsible of the violation of Article 12 in reference to the access to essential health care services because she had no access to "an effective and accessible procedure allowing her to establish her entitlement to the medical services that her physical and mental condition required." And finally, the State violated the Article 16 in relation with Article 1(e) of the Convention because L.C. was deprived of her right to decide on the desired number of children.[435]

This case is important because of the violation of the State of the right to be free from stereotypes as judged by the Court, a vision which many times, takes precedence on many other rights as happened for L.C. Moreover, it reminds that States cannot and should not interfere in the private decision of a person about the number and spacing of their children.

K.L. [436] was only 17 when doctors informed her that the foetus she was carrying had anencephaly, a rare condition that do not permit extrauterine life. She sought for an abortion which was systematically denied. K.L. had to carry the foetus to term and breastfed it for five days after its birth until it eventually died. This had a huge impact on the young's mental health and the state of Perú was find guilty of violation of K.L.'s right to be free from cruel, inhuman and degrading treatment among other violations. This case has been brought before the Human Rights Committee thanks to the organisations Center for Reproductive Rights, DEMUS and CLADEM who alledged for a violation of the International Covenant on Civil and Political Rights, especially of the rights to life (Article 6) which was not found by the committee, prohibition of torture and cruel, inhuman or degrading treatment (Article 7), to a private life (Article 17) for interfering with her private life as the decision of the girl about her body and life has a arbitrarily interference by the State which decided

[435] Ibid. para 8.9

[436] K.L. v. Peru (UN Human Rights Committee 22 November 2005)

on her behalf about her life and reproductive health.[437] In doing so, or better, in obliging her to carry the baby to term, the State of Perú interfered with the girl's privacy. Other articles which were violated are the right to a protection of minor's rights (Article 24) which includes also the enjoyment of the highest attainable standard of health and includes the right to the access to safe abortion services[438], a protection deserved to KL due to her young age and the difficulty she was going through after she found out her baby was not able to live, among others. The abortion is actually not permitted under the Peruvian Criminal Code (Article 120), nevertheless it is allowed for therapeutic reasons (Article 119) in case the no abortion could cause severe damages to the physical and mental health of the woman as happened in the case of K.L. As a matter of fact, the young woman suffered from depression after the experience of her first pregnancy.

One of the most emblematic case is perhaps the case of Alyne da Silva Pimentel v. Brazil[439].It concerns a case of mistreatment who led to maternal mortality and must be studied from the intersectoral point of view. The case was brought before the Committee on the Elimination of Discrimination against Women in 2007 by the Center for Reproductive Rights and Advocaci. This case is the first case on maternal mortality judged by an international human rights body, being considered then as one of the most important in the sexual and reproductive rights jurisprudence. The victim is Alyne, an Afro-Brazilian woman, who lived in one of the poorest districts of Rio de Janeiro. When she was 28 and during her second pregnancy (she was at her sixth month of pregnancy), she sought maternal care from a local health since she was suffering from severe nausea and abdominal pain. In spite of her pain, she was sent home after a prescription of some anti-nausea medication, vitamins and urgent blood and urine test to be performed two days later. In the meanwhile, her conditions worsen and on the scheduled day, she went earlier to the hospital where doctors could not detect her baby's heartbeat. They induced labour the same afternoon and after that, Alyne felt worsen and was advised to move to another hospital but the family could not afford a private ambulance and the other hospital refused to send an ambulance. The woman remained eight hours in critical conditions, the last two of whom almost in coma. When she managed to be moved of hospital, her conditions were transmitted orally to the new health personnel (no medical record was brought) and she was placed in a lobby as no beds were available in the hospital. She finally died at the hospital due to a digestive haemorrhage as a consequence of the delivery of the stillborn foetus who had been dead in her womb for several days.[440]

[437] Ibid. para 3.6
[438] Committee on the rights of the child, General Comment No. 15 on health. 17 April 2013, para 56
[439] Alyne da Silva Pimentel Teixeira (deceased) v. Brazil (UN Committee on the Elimination of Discrimination against Women
[440] Ibid para 2.13

The State of Brazil was found in violation of the right to life (Article 2), right to access to health (Article 12) linked to discrimination against women (Article 1) as "the State party did not ensure appropriate medical treatment in connection with pregnancy and did not provide timely emergency obstetric care, hence infringing the right to non-discrimination based on gender, race and socio-economic background."[441] the right was also violated as the State failed to regulate activities of private health providers (Article 2(e))

An important observation has to be made with respect to Article 12(2): even though the health service that Alyne attended was private, it is the State party which affirms the right to health as a general human right (this State's responsibility is strongly anchored in the Brazilian Constitution (articles 196-200)) even in the case of private health facilities. In fact, States has the responsibility towards people even in behalf of private institutions. Furthermore, through its General Recommendation No. 28, the Committee obliges States to comply with the right to safe maternity and the provision of emergency obstetric care.

The Committee stated also that Alyne was victim of multiple discrimination being a woman of African descent and on the basis of her socio-economic background[442] (intersectionality). In this regard, the Committee recalls its general recommendation No. 28, the same explained in chapter 3, section 3 that recognise the fact that discrimination against women is inextricably linked to other factors such as, as in the case of Alyne, race, ethnicity, religion or belief, health, status, age, class, caste, and sexual orientation and gender identity.

The poor care the woman received may have been a result of a discrimination against her, 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.[443]

4. Barriers to access to justice

There are many reasons that convince a woman not to report a type of violence suffered. Some of these reasons can be typical of many types of violence, some others instead are characteristic of violence suffered with respect to the field of reproductive rights.[444]

[441] Ibid para 7.2
[442] Ibid para 7.7
[443] Ibid
[444] The reasons why women do not report have been taken from Beqiraj J., McNamara L., International Access to Justice: Barriers and Solutions (Bingham Centre for the Rule of Law Report 02/2014), International Bar Association, October 2014, pp. 14-32 and from Palencia E., Contreras J.C. (2007). Análisis de las formas de violencia de género y sus penas como mecanismo para el control del delito en la Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia en Venezuela (Thesis at Universidad Rafael Urdaneta, Maracaibo, Venezuela), pp. 32-45.

First of all, these is still a taboo in many areas of the globe about the reproductive aspects of life and this means that there are many people who, due to their culture, are not feeling comfortable on talking about the problems that can arouse in this sphere. This concerns mainly women who come from rural areas or with a lower degree of education. A low degree of literacy and education in fact makes more difficult the understanding of people's rights and thus, the importance of denouncing their violation. That explains also why, for many women, it is not common to be visited by a doctor. As they are not being accustomed, what they suffer as mistreatment, can be believed to be a normal practice and a normal behaviour in the conduct of health personnel. Furthermore, women with low education are not inclined to question the expert medical practices. This justification also embodies the vision that many people have of doctors, that of infallible persons not to contradict and especially, the only allowed to make decisions for their patients, too.

On the other hand, other women consider that what they suffered is not a serious enough violence to report but a trivial and unimportant event as to involve the police.

Successively many women do not report due to the shame or embarrassment of what happened. Some even blame themselves for the outcome and therefore do not consider they have been a victim but instead they just consider that they did not do their best and thus, it was all their fault. There is therefore a self-blaming of the violence suffered, an aspect that is found in many cases of victims of violence against women.

Another reason is the fact that in many states there are no laws regulating obstetric violence. In case a woman wanted to report a case of obstetric violence, it would not be easy for her, since she would not have a law to support her position as victim. Even where the law exists, often victims are not aware of the existence of it. Another possibility is that even if there were the law, many times lawyers and police do not contemplate the collection of cases of cases of obstetric violence in the absence of victims (child or mother).

The services made available by the state to make a complaint are in fact very little gender-sensitive, undermining some types of violence. Women therefore have a negative impression of the police, a feeling that can have been arouse during a past experience after reporting and having a negative feedback because of judiciaries inadequately trained or qualified to receive reports. Some of these reasons are in fact related to a lack of ensuring a way to access to clear and effective legal service by the state and, for what concerns the staff who receives the complaints, many times they prove to be neither proactive nor understanding towards the victims.

This fact also increases the belief, so often correct, of an inability to report because the police cannot or do not want to take concrete action about the issue. The state, for its part, may not facilitate the report through the difficulty in complaining (no numbers to contact, offices for information about the

issue, leaflets in health facilities, etc...). in this case, there are many associations that deal with reproductive rights and, with the help of experts and lawyers in the field of reproductive rights, can support women who would like to denounce trough the different stages of the bureaucracy (e.g. GIRE in Mexico, White Ribbon Alliance in many countries of Africa and Asia, OVO in Chile and many more throughout the Americas and the world).

Another barrier in the reporting system is that many times there is an insufficient distribution within the territory of reporting facilities and they are often located far from the areas where most of the women who suffered from obstetric violence live. This therefore implies that the victim must bear the costs for the transportation, a financial burden that many cannot afford (that includes many bus hours or walking and precarious communications routes, the time spent to report and the trouble to do so.) A journey that few women who have just given birth are willing to do, especially if fearing to receive the same treatment of discrimination suffered in health facilities. Moreover, poverty is very often connected to a scarce education and literacy which is one of the main causes why women do not report.

Discrimination against, among many characteristics, migrants, women and indigenous peoples is another main factor which can prevent women to denounce the mistreatments they received. When these characteristics overlap, a multiple discrimination is enforced and thus women seeking for help will encounter more difficulties in report the violence.

If no one denounces the violence suffered in the maternity wards, discriminatory and violent behaviours will continue to repeat. And while in some women, these behaviours may have caused minor harm, in many others they can lead to serious consequences, long-term health problems in children, depression problems and post-traumatic stress, among other consequences.

5. The "Maternal Mortality" Factor

Maternal mortalityis defined by the WHO as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."[445]

The main causes leading to maternal mortality are due to a wide variety of factors. Among these, the main responsible factors of about 75% of maternal mortality are:

• severe bleeding (mostly bleeding after childbirth)

• infections (usually after childbirth)

[445] WHO. (n.d.). Health statistics and information systems. Retrieved 29 January 2018 at http://www.who.int/healthinfo/statistics/indmaternalmortality/en/

• high blood pressure during pregnancy (pre-eclampsia and eclampsia)

• complications from delivery

• unsafe abortion.[446]

• obstructed labour

• hypertensive disorders related to pregnancy such as eclampsia[447]

Complications from unsafe abortion are another common and preventable direct cause of maternal death. Indirect causes – conditions or diseases that can lead to complications in pregnancy or are aggravated by pregnancy – include anaemia, malaria and HIV/AIDS.[448]

However, the most significant datum is that, in many cases, these deaths are preventable or they may not turn into deaths if they were taken in time and with adequate care. Indeed, these conditions are largely preventable and, once detected, they are treatable.[449] UNFPA estimates that one in three deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services.[450]

Apart from the caused listed above, there is an interesting model to take into account when explaining in depth some of the causes of maternal mortality. This model is known as the three delays model. It explains three types of delays that women might experience during they search for maternal care and that can led to maternal mortality (or morbidity).[451]

Delay 1 concerns the delay in the decision of the woman or of the family to look for assistance in case of complicacies. This is due to different factors. A limited education on sexual and reproductive issues may not led to immediately spot an obstetric emergency. The cultural environment can refrain to seek immediate care, too. In addition to that, the economic factor can make women desist from seeking maternal care in fear of the amount of money they have to pay for a visit.

Delay 2 occurs when the woman has decided to seek for maternal care but that is not possible to reach in a sufficiently adequate short time due to the material difficulty to access the selected health service. This phase of delay is strictly linked to an institutional lack of means by the government as involves the infrastructural conditions and the distribution of the services within the territory.

Lastly, the third delay occurs when in a health facility the woman experiences delay in receiving care due to many reasons. It might be because of low rate of staff working unable to take care of all patients

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[446] WHO. (November 2016). Maternal Mortality. Fact sheet. Retrieved from http://www.who.int/mediacentre/factsheets/fs348/en/

[447] Center for Reproductive Rights. (September 2010). Submission to the United Nations Office of the High Commissioner for Human Rights for the preparation of the thematic study on Maternal Mortality, Morbidity and Human Rights, p. 5

[448] Ibid.

[449] Ibid.

[450] UNFPA. (n.d.). Reducing Risks by Offering Contraceptive Services at http://www.unfpa.org/mothers/contraceptive.htm

[451] Calvello E., Skog A., Tennerb A. et al. (2015). Applying the lessons of maternal mortality reduction to global emergency health. Bull World Health Organ, 2015(93), pp. 417–423

or due to a shortage of medicaments or a negative attitude towards the woman, above all if she comes from a rural or poor area and/or if she is an indigenous woman.

The three delays can obviously concur to worsen the woman's general health situation.

It has been estimated that 74% of maternal mortality could be averted if all women received appropriate emergency obstetric care.[452]

Maternal mortality is considered such an important lemma in the percentages of women's death that it is also placed among the goals of the MDGs. In 2000 states committed to reduce maternal mortality rates by three-quarters between 1990 and 2015. For the SDGs the target is to reduce the global maternal mortality ratio to 70 per 100 000 live births or less between 2016 and 2030 working towards a vision of ending all preventable maternal mortality. Achieving this global goal will require countries to reduce their maternal mortality ration by at least 7.5% each year between 2016 and 2030.[453]

5.1 Who are the victims?

The WHO estimates that every day in the world, about 830 women die from preventable causes related to pregnancy and childbirth or better, a woman every two minutes.[454] 99% of death of maternal mortality, takes place in developing countries.[455]

For example, the region of Latin American and the Caribbean has a maternal mortality ratio of about 68 per 100 000 live births in women aged 15 to 49 (data 2015)[456].

Nevertheless, this data indicates only the number of women who died due to pregnancy whilst the number of women suffering from disability and illness is much higher. [457] A rate that is second only to the undeveloped regions of Africa. An important fact that, emphasised also by the WHO is that the rate of maternal mortality is much higher for women who come from rural or less rich areas of the country. This same data affects also indigenous women.[458]

The estimated number of women who died for maternal mortality between 1990 and 2015 is of 10.7 million. Nevertheless, since the beginning of the XXI century, there has been a fall of 44% in the

[452] Wagstaff A., Claeson M., Wagstaff A. et al., (2004). The Millennium Development Goals for Health. Rising to the challenges. Washington, World Bank Group, p. 6

[453] Center for Reproductive Rights. (2014). From Risk to Rights. Realizing States' Obligations to Prevent and Address Maternal Mortality, p. 38

[454] Ibid. at 2

[455] Ibid.

[456] W WHO, UNICEF, United Nations Population Fund and The World Bank. (2015). Trends in Maternal Mortality: 1990 to 2015, Geneva, Switzerland.

[457] UNICEF, Ministerio de la Salud de Argentina. (2003). Mortalidad Materna. Un Problema de Salud y Derechos Humanos. Buenos Aires, Argentina, p. 43-44.

[458] WHO. (November 2016). Maternal mortality. Fact sheet. Retrieved 31 January 2018 at http://www.who.int/mediacentre/factsheets/fs348/en/

ratio of global maternal mortality, an average fall of 3% per year worldwide as the WHO estimates.[459] In Latin America and the Caribbean, the fall was even higher; from 16.000 to 7.300 per 100 000 with a fall of 50%.[460]

Among Latin countries, Uruguay proved to be the one with the best outcome. Since 1990, maternal mortality in Uruguay has declined by nearly 70%, being now one of the lowest in the region.[461]

Not all cases of obstetric violence result in the death of the woman or of the new-born nevertheless maternal mortality and stillbirth are among the main reasons why women (or their family) report mistreatments in health facilities.

[459] WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. (2015). Trends in Maternal Mortality. 1990 to 2015, p. 20
[460] Ibid. p. 21
[461] Ibid at 453, p. 13

Chapter 5. What's next?

Contents: 1. Projects of Law; 2. What's next?

In this brief last chapter, further projects and initiatives will be discussed. First of all, the new projects of law that in many countries of Latin America are waiting to be approved in the Congress, later on some initiatives related to the issue of obstetric violence in the region.

As seen, in Latin America there has been in the last years a strong interest in the subject of obstetric violence which is leading to the adoption of national and / or state laws for the recognition and subsequent criminalization of this practice. Already in at least six countries the type of obstetric violence has been recognized nationally or state-wide and many other Latin American countries are submitting draft laws to their congresses to ensure that they approve a law that recognises it. This knowledge is also spreading outside Latin America to reach other areas of the globe, for example in Europe.

In 2015, the WHO has reiterated the need not to exceed a percentage rate between 10 and 15% for Caesarean sections, a percentage that is not respected neither in Latin American nor in other regions of the world such as in Europe. For example, Italy shows a percentage of Caesarean sections which is double (36.3%) the rate recommended by the WHO. Also in Italy a proposal for a law on humanised childbirth was presented in March 2016. [462] The law is called "Rules for the protection of the rights of the mother and child and for the promotion of physiological childbirth" and it will also include the crime of obstetric violence with a sentence of two to four years of jail for perpetrators. In other European countries the same battle is taking place, thanks also to the feminist movements and the raise of numerous associations concerning the reproductive rights of women.

1. Projects of Law

In Latin America, movements for the recognition of obstetric violence in national laws are spreading and multiplying.
For example, Chile is waiting for the approval of the law that includes the concept of gynaeco-obstetric violence. The project of law has been held in Congress for years waiting to be discussed. In

[462] Camera dei Deputati, project of law C.3670"Norme per la tutela dei diritti della partoriente e del neonato e per la promozione del parto fisiologico". Roma, Italia, March 2016. Available at http://www.camera.it/_dati/leg17/lavori/stampati/pdf/17PDL0039650.pdf

2015 Members of the Chilean Congress Marcela Hernando and Loreto Carvajal submited a Project of law (Proyecto de Ley que establece los derechos de la mujer embarazada en el trabajo de parto, parto y el posparto, además de sancionar la violencia gineco-obstétrica).
Likewise, the draft law for human birth (Ley por el Parto Humanizado) is waiting to enter parliament. This law has now taken the name of "Ley Trinidad" from the name of a child born dead for obstetric violence. The mother, a 19-year-old Chilean woman, had tried six times to be visited for severe pain during her 40th week of gestation and was promptly sent home as there was not enough dilation to allow childbirth. Trinidad died of foetal distress still in her mother's womb. The family of the young woman then decided to appeal to Article 491 of the Chilean penal code[463] which establishes a fine of "imprisonment or fine of eleven to twenty monthly tax units"[464] in the event that "the doctor, surgeon, [...] or midwife [is] culpable of negligence in the performance of their profession."[465]

In Colombia, on the other hand, a first draft law on human birth appeared in 2009 (draft law 172) and reported in article 8 that "any form of violence during the care of pregnancy, delivery or postpartum to the pregnant woman, the new-born or their family, will be considered a violation of human rights." A draft law on obstetric violence[466] was presented by Senator Nadia Blel Scaff in October 2017, which provides measures to prevent and eradicate obstetric violence in Colombian public and private hospitals. As reported by the same senator in the presentation of the law, Colombia has in fact a rate of caesarean birth between 25 and 30% as well as other lack by the actual health system.[467]

In Mexico, senator Diva Hadamira Gastélum Bajo, president of the Commission for Gender Equality, presented in 2013 a proposal[468] for the modification of the law at the national level (Ley General de Acceso de las Mujeres at a Vida Libre de Violencia of 2007) to include obstetric violence. It is necessary to recall that in Mexico, obstetric violence is only recognized in the state laws of twenty states and criminalized only in five of these while at national level there is still no law in this regard.

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[463] Civil Code of Chile, Articles 490 and 491. Santiago de Chile, Chile. Available at https://www.leychile.cl/Navegar?idNorma=1984#4910
[464] A Chilean monthly tax unit (Unidad Tributaria Mensual) corresponds to 46.692,00 Chilean pesos (approximately € 62.17) which means that the fine is between € 684 and € 1243.40
[465] Ibid at 397
[466] Senado de la Republica de Colombia, project of law "por medio del cual se dictan medidas para prevenir y sancionar la violencia obstétrica". Bogotá, Colombia. 18 October 2017.
[467] Current situation of the project of law on obstetric violence in Colombia available at http://leyes.senado.gov.co/proyectos/index.php/proyectos-ley/periodo-legislativo-2014-2018/2017-2018/article/148-proyecto-de-ley-por-medio-del-cual-se-dictan-medidas-para-prevenir-y-sancionar-la-violencia-obstetrica Last accessed 07 February 2018
[468] Project of Law Iniciativa para adicionar una fracción al artículo 6 de la ley general de acceso de las mujeres a una vida libre de violencia con la finalidad de regular la violencia obstétrica en Mexico, November 2013. Available at http://infosen.senado.gob.mx/sgsp/gaceta/62/2/2013-11-12-1/assets/documentos/Ini_Diva_art.6_VIOLENCIA_OBSTETRICA.pdf

The request for modification of the law has been approved but there has not yet been any national confirmation of the amended state law. Nevertheless, in 2016, Mexico approved the national law NOM-007-SSA2-2016[469] which establishes the minimum criteria for the medic attention during pregnancy, labour and for the health of new-borns.

A draft law on humanized childbirth was also presented in Peru[470] in October 2017, where for example the rate of C-sections in private health facilities is 50%. The draft law does not provide for the sanction of obstetric violence, although this is still a starting point for the recognition of the rights of pregnant women and their new-borns to later develop also the concept of obstetric violence as happened in Argentina.

Also Brazil, the country with the highest rate of caesarean birth in Latin America and among the highest in the world, is taking provisions to include obstetric violence in the framework of state laws. For example, the law proposed by Senator Leci Brandão in 2017 for the state of Sao Paulo. [471]

2. What's next?

Great changes have taken place in the last few years, even at the global level. For example, the IFMSA (International Federation of Medical Students Association), which is one of the largest federation of students in the world with the aim to achieve a healthier world sharing knowledge and adopting common politics among future physicians[472] showed great interest in relation to the topic of pregnancy and delivery. As a matter of fact, it stated that medical students "should aim and be totally equipped to be able to transform the process of child delivery into a natural, spontaneous and unrestrained process in order for it to take its right place in every mother as the moment she were able to grant life to a new human being."[473]

Furthermore, it has even suggested that medical students should by the end of their medical education years "be able to have helped in an entire process of normal child delivery."[474] There is then, also at

[469] Norma Oficial Mexicana NOM-007-SSA2-2016 para la atención de la mujer durante el embarazo, parto y puerperio, y de la persona recién nacida, 7 April 2016. Available at http://www.cndh.org.mx/sites/all/doc/Programas/VIH/Leyes%20y%20normas%20y%20reglamentos/Norma%20Oficial%20Mexicana/NOM-007-SSA2-2016%20Embarazo,%20parto%20y%20puerperio.pdf

[470] Congress of Perú, project of law 1986/2017 for the promotion and protection for a humanised birth and the health of pregnant women and new-borns, 9 October 2017. Available at http://www.congreso.gob.pe/Docs/comisiones2017/Comision_de_Salud_y_Poblacion/files/proyecto_de_ley/proy_ley_1986.pdf

[471] Lei 1130/2017. Available at https://www.al.sp.gov.br/propositura/?id=1000196412

[472] For more information, https://ifmsa.org/

[473] IFMSA. (2017). Policy Document Obstetric Violence and Humanized Birth. Budva, Montenegro. Available at https://ifmsa.org/wp-content/uploads/2017/08/GS_2017MM_Policy_Obstetric-Violence-and-Humanised-Birth.pdf

[474] Ibid p. 7

international level, a recognition of the need to go back to a natural process of birth, less pathologic and more authentic.

In Latin America, there are a wide range of differentiated projects and initiatives to raise awareness of the issue of obstetric violence, and thanks to many associations interested in women's reproductive rights and not only, the problem has begun to spread all around Latin America. That results in a consequent heavy pressure on the decision-making bodies. Furthermore, the diffusion of the theme means that more and more women are aware of it and, when they recognise themselves in the description of the victim, can denounce and contribute to a future eradication or at least to a sensitive reduction of the indexes of procedures that can be identified as obstetric violence in health facilities such as a lowering of caesarean indexes, episiotomies and other procedures that are not recommended in the case of childbirth without complications. This would hopefully increase the rate of 'more' physiological and natural births.
Given that, it is necessary to start from the roots to eradicate the problem since the problem of medical violence is already present among medical students. In this regard, for example, reproductive rights have been taught in the last years throughout many Argentinean universities. In the province of Rosario, the Escuela de Medicina de la Facultad de Ciencias Médicas de la Universidad Nacional de Rosario has the possibility for medical students to attend an elective course in health and human rights. The course includes three cycles with a perspective on human rights intersected in each cycle.[475]

Argentina have also activated a phone number to help women to denounce obstetric violence as well as a campaign to distribute leaflets in the waiting rooms of the health facilities, above all in their maternity wards, with instruction and information about the positive aspect of having a humanised birth.

Venezuela has also adopted the National Humanized Birth Plan (Plan Nacional Parto Humanizado) for a birth delivery with no pain as part of the measures for the empowerment and protection of women. The plan contemplates the right of pregnant women to be provided with truthful information about the procedures they will undergo during their labour as well as the right to make autonomous decisions with the advice of health personnel.[476]

[475] CLADEM, INSGENAR. (December 2008). Con todo al Aire II., p. 22
[476] Venezuela impulsa el Parto Humanizado como derecho de la mujer. 13 September 2017. Retrieved 01 February 2018 from http://minci.gob.ve/2017/09/venezuela-impulsa-el-parto-humanizado-como-derecho-de-la-mujer/

Coherent with what states, on July 2017, the government approved 12 billion bolivars for the implementation of the plan, which includes the training of 10 thousand promoters of the humanised birth in a first stage, who will later join their communities to inform people about the rights of women and the family, as well as to accompany and guide pregnant women in the knowledge of their pregnancy and delivery process.[477]

Indeed, governments should understand that it is economically more convenient to invest more in the services to offer in order to reduce the costs in the medium and long term. As an estimate from the USA states "access to modern contraception is not only a human right, but a smart investment of development assistance. Spending one dollar on contraceptive services reduces the cost of pregnancy-related care by $1.47.47"[478]

[477] Ibid

[478] Center for Reproductive Right. (2017). 2017-2018 Federal Policy Agenda. Continuing the Fight for Reproductive Rights and Access to Care, p. 18

CONCLUSION

In the last decade we have witnessed an increase in the knowledge and legal positions taken with regard to the issue of obstetric violence, a theme that is still little known and little analysed and present at the national level (with the exception of few cases) and that is, especially at international level, not formally addressed yet. Obstetric violence is part of the results of a long struggle for women's rights that began last century and which led to the adoption of comprehensive laws against various types of violence against women in several countries in Latin America, an area characterised by high rate of violence against women and also of obstetric violence as defined in the study.
This fact should be understood as a need for a recognition and a formal address of this type of violence which is wide spread and that has been considered the norm for too long as a result of a constants pathologisation of a natural event.

Analysing the most frequent forms that obstetric violence can take, it results that many of the physical procedures routinely used are considered as dangerous both under the medical and psychological point of view. It is precisely for this reason that WHO has published many guidelines and studies in which it shows their negative effect on women's health and subsequently also the standards within which it is advised to remain when these procedures must be performed for medical reasons. In many cases, however, these standards are not met. Also the verbal acts which are always part of obstetric violence, deeply affect the dignity of the woman with severe consequences for the general outcome of the delivery, for the health of the new-born and for the same woman.
For the harm these practices can cause on both the physical and the psychological health of women, it is possible to state that obstetric violence is indeed a form more of violence against women, most precisely against pregnant women, which severely affects women and which can lead to serious consequences. That is due also because of the sensitive period of life pregnant women live since they result more vulnerable both physically, due to the risk that pregnancy might involve, and mentally due to the conditions of taking care for them and their baby.

From a legal point of view, it resulted that there are no international rules which specifically address obstetric violence. Nevertheless, analysing the articles relating to the reproductive sphere both internationally through binding and not-binding tools and at various national laws, there are numerous rights that are violated when obstetric violence is performed. Even though no precisely addressed in the text of international and regional documents then, obstetric violence violates many human rights and thus can be definitely be considered as a violation of human rights.

The documents which embed human rights have been signed and adopted by the major part of the states of the international community thus they compromised to guarantees those rights which are actually violated in the maternity wards of their health facilities.
As a consequence, is it also possible to state that obstetric violence can be considered as part of institutional violence since the state, which committee to guarantee the freedoms and the exercise of the rights belonging the reproductive field, often fails to do so both directly and indirectly not providing adequate health services or/and ancillary services strictly connected with the enjoyment of health care and especially of maternal care. Under the umbrella of institutional violence, it is necessary to remind that the health personnel of public health facilities, the material perpetrators of obstetric violence, are state employees and thus, the final culpability falls on the state also when it is not directly responsible for the violence and the violation of the aforementioned rights.

To support the thesis of obstetric violence as a type of violence against women and as a lack of human rights, there are many cases which even if they do not directly address this type of violence, can indeed constitute an important corpus for the jurisprudence. These cases, at both international and regional level, concern different situations which present some aspects in common with cases of obstetric violence. In the cases presented, it is in fact possible to notice many similarities with some practices illustrated at the beginning of the work and above all the mistreatment or poor attention towards women when they search for health care. All the analysed judgments clearly condemn the violation of many rights which are violated by obstetric violence, too. In all cases, the state has always been held responsible for the violation of a number of rights related to pregnant women and above all, to women belonging to the most vulnerable sectors of the society in accessing health services.
In this regard, a special focus has to be given to the inequality that many times can be noticed in the care provided. Despite the fact that all women can be victim of obstetric violence, it is important to notice that mistreatments and abuses in health facilities are often addressed towards women from the most vulnerable sectors of the population who are more likely to be victim of obstetric violence such as indigenous women or poor women. Furthermore, in many cases it is possible to notice the overlap of two or more characteristics of discrimination present at the same time in the same person (intersectionality). In these cases, the violence suffered by the woman is twofold or multiple. This aspect is also linked to the fact that many of these women experience a great degree of difficulty when they have to reach health facilities. In fact, it is noted that these are far from the areas where they live and it is difficult to reach these facilities for those people who are not endowed with economic resources and experience other social, cultural and also infrastructural barriers.
Undoubtedly, the courts often recognize the presence of a double or multiple basis of discrimination which intersect in the same person, nevertheless the approach of intersectionality should be

implemented by international and regional courts and bodies to permit a more specific address to some cases in which women suffer discrimination on two or more grounds.
The approach of intersectionality is of paramount importance and should also be considered by governments when projecting and adopting new laws or taking measures in order to combat this type of violence more effectively.

As obstetric violence is still a subject which has not been addressed in many studied, there are still many issues to address in the coming years alongside the evolution of the jurisprudence concerning obstetric violence.
Given the lack of awareness of this type of violence even in countries where it is typified, it should be investigated whether women are informed about their rights and know how to recognize whether they have been victims of this violence. With more and more countries typifying it, it should be interesting to study if there is an effective growth in the number of reporting (which would help to tackle this type of violence) or whether the increase is modest and not relevant. That may happen because of the extreme negative experience women already experienced in the health facilities and their reluctance in dealing with state institutions again.
A future analysis would be useful also to study whether there is a change in the behaviour and practice of new doctors, nurses, and health personnel to see if they were trained with a view to a more humanised birth, as a natural, physiological event or they continue to put in practice the precepts and the teachings of birth as a pathology.

Despite the fact that the first law on obstetric violence has been approved more than ten years ago, only in recent years more and more countries are recognising the existence of this issue throughout their health facilities and are including it in their national laws which marks a recognition of the problem by the governments and their formal will to tackle it, not only in Latin America but also in the rest of the world, particularly in Europe even though Latin America is still the area where the topic is most discussed and addressed. At the moment there are several Latin American countries that have presented a project of law in the congress of their country in order to typify it in their national law and in many more countries there are feminist movements and actions for the protection of reproductive rights which are arising the issue of obstetric violence demanding for more protection during pregnancy, labour and in the afterbirth in the maternity wards as well as the respect and implementation of a series of rights concerning the topic.
For this reason, it would be interesting to study the consequences of the spread of the recognition of this type of violence throughout Latin America in the next few years, when many more countries will have approved the law and when it will be possible to conduct research on the results obtained with

the implementation of laws, regulations, and other measures against obstetric violence to see if there is an effectiveness in lowering the rates of caesareans or episiotomies and the negative attitudes towards pregnant women, above all towards Indigenous, poor women and other vulnerable categories of women.. Indeed, much more needs to be done in order to reach a formal international recognition of this violence and without a doubt, Latin America is an example to consider for the rest of the world regarding the efforts that the region is making to tackle this type of violence against women.

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