



What Care for Birthing Mothers? The Relevance of UDHR Art. 25 in the Framework of Obstetric Violence in Italy and Portugal

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Abstract

Obstetric violence (OV) was first defined in 2007 in Venezuelan law as gender-based violence (GBV), i.e., having structural roots rather than happening in contingent or subjective situations. In Venezuelan Law, OV is framed as breach of multiple human rights of women (e.g. right to life, right to be free from violence, and right to health): more recently, international human rights law has followed suit– recognizing that pregnancy and childbirth care must be provided according to the principles enshrined in article 25 of the Universal Declaration on Human Rights (UDHR), the right to health. Its actual implementation, however, still shows a cleavage between standards and practice. This work seeks to examine the meanings of the term “care” in art. 25 UDHR in international, regional, and domestic legal documents and its actual articulation. Support to such critical analysis is provided by scientific literature, providing a review of the legal notion of OV and its prevalence in the context of analysis. This work focuses on Italy and Portugal - countries particularly relevant for the recent developments of the subject matter in Europe, also in light of the influence exercised by Latin American activism through Spanish activism. While the meaning “care” in the context of childbirth is quite deep and comprehensive in human rights standard-setting instruments, also highlighting how OV disrupts such care by jeopardizing the agency, dignity, health, and self-determination of the birthing person, such care is still not up to those standards – in jurisprudence as well as in the daily reality of the analyzed countries.

Keywords: childbirth, gender-based violence, human rights law, SRHR, feminist activism

1. Introduction

Obstetric violence (OV) was first defined in 2007 in the Venezuelan legal framework within the Organic Law on the Right of Women to a Life Free of Violence as “the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, 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.” (Ley Orgánica sobre el derecho de la Mujer a una Vida Libre de Violencia, 2007, art. 15), typifying the forms of violence committed by any healthcare facility staff in any event of a woman’s sexual and reproductive life. This violence may take different forms, as documented in scientific literature (Barbosa Jardim and Modena, 2018; Bowser and Hill, 2010), including a variety of harmful treatments and non-consensual measures, but also psychological or physical violenceⁱ. The approval of this legal measure is particularly relevant and innovative in its kind, in that it is the first one recognizing OV as a form of gender-based violence (GBV) and, as such, as having structural roots rather than happening in contingent or subjective situations (Pérez D’Gregorio, 2010). Venezuela’s approach has inspired similar legislation in Argentina, Chile, and some States in Brazil and Mexico; these developments have fostered international debate and, having been by fueled grassroots movements advocating for women’s sexual and reproductive life, they built a foundation for scientific research in different fields (medicine, anthropology, sociology, gender studies, law) and a precedent for other States outside Latin America to move in the same direction – also in the light of the growing scientific evidence that abuse and disrespect during pregnancy and childbirth is present worldwide and is not a prerogative of resource-scarce health settings (Bowser and Hill, 2010). In Venezuela’s Organic Law, OV is framed as a breach of multiple human rights of women, among which are the right to life, the right to be free from violence, and the right to health, which in episodes of OV is jeopardized by obstetrical care.

Drawing inspiration to one section of article 25 of the Universal Declaration on Human Rights (UDHR), this work seeks to examine the meanings that have been attributed to the term “care” for women in the context of childbirth in legal documents, and what such attribution of meanings would imply in practice with regards to the quality of care. To be sure, OV is not confined to childbirth; it can take place in any stage of a woman’s sexual and reproductive life and outside medical facilities: this work focused on hospitalized childbirth to limit and deepen the analysis of the subject matter. For the purposes of this work, childbirth is defined from the entry of the birthing woman into the health facility where she will give birth. Therefore, “childbirth” encompasses all the phases from dilation to labor and expulsive phase, as well as the immediate aftermath of childbirth, until the woman is dismissed from the labor room or the surgery ward. OV in the context of childbirth can also occur in subsequent moments, until the woman and the newborn baby are dismissed from the health facility, or in postpartum medical check-ups.

To carry out this analysis, I am going to revise legal documents which refer to the right to health in hospitalized childbirth care. I am going to include jurisprudence and documents belonging to the International Human Rights Law arena, including both hard law, such as International Conventions, and soft law, such as General Comments (GC) and Recommendations of international Human Rights bodies and United Nations (UN) General Assembly Resolutions; moreover, the review will include the relevant documents issued by the World Health Organization (WHO), which are not legally binding but do constitute an authoritative voice on the analyzed issue; relevant European regional instruments are also accounted for. As for the national level, this work will involve the legislation of Italy and Portugal, for the purposes of an ongoing PhD research project in these geographical contexts.

Such countries are particularly relevant for the subject matter, due to legislation approved in 2019, in the case of Portugal, and pending approval since 2017, in the case of Italyⁱⁱ.

An increasing number of studies (Fernández Guillén 2015; Tamayo Muñoz et al, 2015; Sadler et al, 2016; Vargas Rojas 2018) from all over the world testifies the current situation of human rights in childbirth in different countries, interviewing both birthing women and, to a lesser extent, health professionals to perceive their view and perspectives on the issue. These investigations, however, have focused mainly on low-income settings: a great number of them is set in Africa and Latin America, but less attention has been dedicated to higher income countries located in Europe, Australia, and the United States. This is another reason why this work focused on two high-income countries, where resource scarcity or the quality of infrastructures does not - at least in principle - hamper the quality of care.

The work will be carried out through the following steps: (a) “*special care and assistance*”: content and definition of such terminology in official human rights documents, issued by the UN and the WHO, and within the European human rights systemⁱⁱⁱ, defining the extent and nature of care (does the term refer to medical care? Or to a broader notion of it?) to be provided for the birthing mother within the jurisdictions examined. In this phase, I endeavor at hypothesizing the legal discourse underlying these notions of care. Subsequently, (b) defining the type of care advocated for by civil society organizations and activist movements. Finally, (c) examining any gap between these notions through the analysis of national data compared to the legal standards examined, in the geographical contexts of Italy and Portugal.

The work will be developed with reference to OV, considering the relevance of applicable law on the right to health for the prevention and elimination of this form of violence against the human rights of women and, in general, birthing persons.

2. “Special Care and Assistance” during Pregnancy and Childbirth: A Review of International (Human Rights) Law Documents, National Laws, and Jurisprudence

In this section, international law documents (including, but not limited to, human rights law) will be resorted to, in order to provide the big picture in which the right to health in childbirth fits.

The right to health is sanctioned by numerous human rights documents, the first of which was the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), whose art. 12 protects “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”: an important remark to this notion of health is that it is an all-encompassing one, stemming from a holistic approach to the definition of health, to be guaranteed to its “highest attainable standard”.

The ICESCR Committee (CESCR) issued a GC on the right to health, GC 14 (2000), which refers to women’s reproductive and sexual health by demanding signatory States to guarantee the “right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.” and requires “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”. Another relevant GC issued by the CESCR is GC 22 (2016) on the right to sexual and reproductive health, which recalls that “The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health”.

Within the UN framework, another soft law instrument deserves a mention: the Universal Declaration on the Human Genome and Human Rights (1997) establishes that “human dignity, human rights and fundamental freedoms are to be fully respected” in medical contexts, including childbirth care, thus adding up to the documents referring explicitly to the right to health.

The ICESCR draws its notion of health from the WHO’s definition, sanctioned in its 1947 Constitution as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The WHO Constitution makes no particular reference to childbirth care, but the fact that it takes a broad approach to the definition of health is relevant for this work, in that it forms a solid basis for the so-called “humanization of childbirth” (Gonçalves da Silva et al., 2014) as a patient-centered tool to prevent and eradicate OV and, more in general, poor childbirth care.

The WHO has also provided (non-binding) guidelines and documents on the rights of women in childbirth, first and foremost the right to health, starting in 1985 with the *Appropriate Technologies for Birth*: in this document, the WHO lists the rights of the birthing woman as including the right to information and choice, emotional support, mother-child attachment, and warns about unjustified medicalization (see Chalmers, 1992). In 2014, the WHO issued the *Statement on Prevention and elimination of disrespect and abuse during facility-based childbirth*: in it, the WHO upholds the human right of women to a dignified, respectful care during childbirth in the framework of the right to the highest attainable standard of health and of the right to be free from violence and cruel, inhumane and degrading treatment. It also recalls the importance of “the rights to life, health, bodily integrity, and freedom from discrimination”.

In recent years, the WHO has adopted the “Standards for Improving Quality of Maternal and Newborn Care in Health Facilities” (2016) and the “Recommendations for Intrapartum care for a positive childbirth experience” (2018). These documents go into detail defining the content of the right to health of birthing women and how it should be guaranteed at an operational level, defining “normal childbirth”, “healthy pregnant women and girls”, and the measures during childbirth which are regarded by the WHO as “recommended”, “not recommended”, and “recommended only in specific contexts” in each childbirth phase. Among the recommended procedures, many of them are also advocated for by activists for human rights in childbirth: respectful and non-discriminatory maternity care - free from harm and mistreatment- , ensuring that informed consent has been obtained on any practice performed, allowing for one person to accompany the woman during childbirth, refraining from unnecessary and potentially harmful practices (enemas; pubic shaving; routine episiotomy; procedures to accelerate dilation and to induce labor; continuous cardiotocography; non-medically indicated C-sections), allowing for positions of the woman’s choice and for food and drinks in the first stages of labor, ensuring skin-to-skin and contact between mother and baby, providing facilitation of maternal lactation.

Interestingly, while the WHO refers multiple times to unnecessary, non-evidence-based, and harmful measures during childbirth, it never mentions the term “obstetric violence”: this is probably due to the reticence by the international medical community to accept such term to define abused and mistreatments during childbirth (see Katz *et al*, 2020).

Other UN Conventions protect the right to health, but the most relevant to our ends is the 1979 UN Convention on the Elimination of Every Form of Discrimination Against Women (CEDAW), which provides in its art. 12 that “States parties shall ensure to women 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”.

The CEDAW Committee also issued General Recommendation 24 (1999), which encourages “States parties to refrain from obstructing action taken by women in pursuit of their health goals” and to “ensure access to quality health-care services, for example, by making them acceptable to women. Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.” Moreover, GC 24 establishes that “Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives.”, and requires that within State Parties “all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice”. Notably, the rights sanctioned in GC 24 are the very rights which suffer breaches when OV occurs: the document, however, does not have binding force, which means it cannot be enforced for governments who are Parties to the CEDAW.

In the 1995 Beijing Declaration and Platform for action by UN Women, governments declared the intention to “ensure equal access to and equal treatment of women and men in education and health care and enhance women’s sexual and reproductive health as well as education”, and “the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth with the best chance of having a healthy infant”.

These three instruments set high standards for women’s right to health, reminding that healthcare should be appropriate (interpretable as “suitable to the individual need and situation”) and non-discriminatory (therefore, no ill-treatment of violence should occur), especially as far as sexual and reproductive rights are concerned.

The last UN human rights document addressed specifically to women’s human rights is the 1993 Declaration on the Elimination of Violence Against Women, which mentions violence as a violation of, among others, the human right to health of women, but does not refer to violence occurring in healthcare settings.

The Treaty body of the UN Convention on the Elimination of Every form of Discrimination Against Women (CEDAW Committee) ruled for three times on OV cases, the first time in 2020 – in all cases, the State Party concerned was Spain (CEDAW Committee 2020, 2022, 2023). Such jurisprudence shows a now established customary habit of including the notion of OV amongst the various forms of violence against women (a form of discrimination, according to CEDAW GC 19) in the international human rights arena. It also testifies to a restless effort by feminist activists who have been working on strategic litigation exactly to establish such “habitus” to create pressure for their governments.

Insofar as Europe is concerned, the Council of Europe (CoE) is the framework of reference. The European Social Charter’s art. 11.2 invites States to “to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health”, thus stressing the importance of formation and education, not only of health professionals but also of patients, to foster their own autonomy and rights.

The Convention on preventing and combating violence against women and domestic violence (Istanbul Convention, 2014) is a landmark one in that it constitutes the first legally binding instrument combating violence against women (the CEDAW only integrated violence with General Comments, its text only refers to discrimination based on gender). The Istanbul

Convention lists different forms of violence, including sexual violence and violence in the reproductive realm, such as in the cases of forced abortion and sterilization.

The European Convention on Human Rights and Biomedicine (Oviedo Convention, 1997), finally, established the “equitable access to health care of appropriate quality”; stressing aspects such as informed consent; in emergency situations, the Convention states that “any medically necessary intervention may be carried out immediately for the benefit of the health of the individual concerned.” At the European Union (EU) level, the document enshrining human rights in the framework of application of the EU law is the Charter of Fundamental Rights of the European Union (2012), whose art. 35 reads “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.”

One last document is worth mentioning in the European framework: it is not issued by the CoE nor by the European Union, but by a network of civil society members and is therefore non-binding: the European Charter of Patients’ Rights (Active Citizenship Network, 2002), with its art. 11 providing that “The health services must guarantee (...) flexible programmes, oriented as much as possible to the individual, making sure that the criteria of economic sustainability does not prevail over the right to health care”. Not only the right to health, but also the integrity of the person are protected in this charter, in a way relevant to the context of OV: art. 3.2 provides that “In the fields of medicine and biology, the following must be respected in particular: the free and informed consent of the person concerned, according to the procedures laid down by law. (...)”(Active Citizenship Network, 2002). This article makes it clear that neglecting a person’s pleads to receive information on the medical treatment they are about to receive constitutes a violation of human rights and a breach of European law.

It is quite relevant to notice, however, that none of these instruments, not even the Istanbul Convention (which addressed violence against women specifically), mentions the event of childbirth and what the right to health implies in that case.

As for the European jurisprudence of the European Court of Human Rights (ECtHR), this paragraph will mention some of the cases which are most relevant to show the application of the high standards of care enshrined in the documents discussed so far. Some cases do not refer to the right to health directly: however, it can be argued that, according to the broad notion of health welcomed by the examined human rights instruments, the protection of other rights (such as the right to privacy and family life, which was at stake in all mentioned cases) is one relevant aspect of a person’s health status and integrity, and that reproductive rights are also relevant to the realms of bioethics, such as the issue of abortion, assisted procreation, and forced sterilization. It should be noted that it is hard to find cases presenting human rights violations as acts of OV in the European jurisdictions, simply because no law so far mentions the concept as such.

One case related to abortion and women’s health took place in Poland: in the case of *Tysiāc v. Poland* (2007), a pregnant woman who suffered from serious sight problem was medically advised not to give birth, or her issues would sensibly worsen; she then sought to have an abortion performed but could not find any physician available. She finally gave birth, with negative consequences on her health status. The Court ruled that there had been a violation of the European Convention on Human Rights (ECHR) art. 8 on private life, but no violation of art. 3 on cruel, inhumane, and degrading treatment. In this case, the “special care” to which pregnant and birthing women are entitled according to numerous human rights instruments, was partially emptied of its meaning and substance.

Three cases refer to situations of home birth: in *Pojatina v. Croatia* (2019), the applicant, who refused to give birth in a medical facility, had a home birth with a midwife from abroad because she could not find any Croatian personnel willing to assist a home birth (which was not legally allowed in the country); her newborn baby and herself were initially refused medical consultation after birth from national health professionals, due to the home birth. The Court ruled that there was no breach of art. 8, due to the margin of appreciation allowed to States to regulate complex issues such as home birth; as for the refusal of care, the Court ruled on the grounds that the applicant had never reported such refusal to any national authority. Another case regarding home birth is *Ternovzsky v. Hungary* (2011), very similar to the case of *Pojatina*; in this case, the Court recognized that there had been a breach of art. 8: this is because, unlike Croatia, Hungary had not adopted any regulation on home birth and nevertheless discouraged it, thus interfering in women's own choices and private life.

In *Dubská and Krejzová v. the Czech Republic* (2016), two women wanted to have a home birth, but the national legislation did not permit it. One of them gave birth at home with no medical assistance, while the other ended up accepting a hospitalized childbirth. They both resorted to the ECtHR, which ruled against them, with five judges presenting dissenting opinions – an opinion that, following the State's decision, hampers these women's self-determination and agency in childbirth (Chen and Cheeseman, 2017). One of their objections, however, is interesting in the framework of this study: "Patronizing attitudes among health personnel should not be taken lightly, as they may constitute a violation of an individual's right to self-determination under the Convention". This highlights the notion, though not unanimous, that the relationship between health professionals and patients - especially women, who are often subjects of patronizing attitudes due to their gender - should be taken into account when looking at the merits of cases regarding patients' rights.

Another thematic cluster in the ECtHR jurisprudence on women's human rights in childbirth is forced sterilization: in the case of *L.H. v. Latvia* (2014), the applicant experienced forced sterilization during a Caesarian birth due to uterine rupture during labor; the Court identified a violation of art. 8, linked to the collection of arbitrary data on her health status which caused the decision to sterilize her without her consent. *V.C. v. Slovakia* (2012) is an even more interesting case, as the applicant was of Roma origin; the Court ruled that art. 8 ECHR had been violated, recalling norms protecting human freedom and dignity as established in the WHO Declaration on the Promotion of Patients' Rights in Europe, as well as non-discrimination, such as the CEDAW. In both cases, women's right to the "highest attainable standard of health" in the framework of childbirth care has clearly been breached.

The ECtHR found a violation of ECHR art.8 on private life and privacy even in the case of *Konovalova v. Russia* (2015), in which the parturient had been forced to give birth in the presence of medical students without her consent in a university hospital, and in the case of *Hanzelkovi v. the Czech Republic* (2015), where an order obliging a healthy mother and her newborn son to be hospitalized after leaving the hospital immediately after childbirth was ruled as a breach of the mother and baby's human right to private life and privacy. In the case of *Csoma v. Romania* (2013), a woman received poor childbirth care in occasion of a medically indicated abortion, which then led to the need of removing her uterus with evident life-long repercussions. The Court ruled, once again, in favor of a breach of ECHR art 8.

Abundant jurisprudence on cases of OV linked to the right to health, as well as to other human rights of women, can be found in the jurisdiction of the Inter-American human rights system, which, however, does not fall into the scope of this work.

3. Developments on OV within the International and Regional Human Rights Framework

Steps forward have been taken within the UN Special Procedures (namely, the former Special Rapporteur on Violence against Women, its causes and consequences Dubravka Šimonović), UN Treaty Bodies (CEDAW, in particular), and within the CoE.

The former was the Report on “A human rights-based approach to mistreatment and violence against women in reproductive health services, with a focus on childbirth and obstetric violence”, dated July 11th, 2019, submitted by Šimonović to the UN General Assembly. The report, created with the WHO’s support, “aims to apply a human rights-based approach to the different forms of mistreatment and violence that women experience in reproductive health services with a focus on childbirth and obstetric violence”, as stated by the UN Office of the High Commissioner on Human Rights (OHCHR) in 2019. The report is particularly relevant and innovative, in that it frames OV as (1) a human rights violation and (2) as a result of patriarchal patterns of discrimination based on women’s gender. It encourages States to “protect and fulfil women’s human rights, including the right to highest standard attainable of physical and mental health during reproductive services and childbirth, free from mistreatment and gender-based violence, and to adopt appropriate laws and policies to combat and prevent such violence, to prosecute perpetrators and to provide reparations and compensation to victims.” (OHCHR,2019). It suggests action at different level: through education against discrimination and stereotyping as well as training for health professionals, funding, creation of accountability paths, provision of more staff and resources to maternities (OHCHR,2019).

Within the Council of Europe (CoE), on October 3rd, 2019, the Parliamentary Assembly (PACE) adopted Resolution 2306 on Obstetrical and Gynecological Violence, fostered by a report of the Committee on Equality and Non-Discrimination by rapporteur Maryvonne Blondin. The Resolution recalls the Istanbul Convention and the already mentioned UN report, defining OV as a form of gender-based violence and calling for healthcare informed by a human rights approach, gender-aware, and focused on the principle of human dignity. The Resolution acknowledges the challenges that health professionals have to face (e.g. staff shortage or excessive workloads), while it “deplores all forms of violence against women, including gynecological and obstetrical violence, and calls for all necessary preventive measures to be taken and for the human rights of all to be upheld, in particular in the health care context”. The peculiarity of the Resolution is its focus on humanized care, along with a human-rights approach which fully acknowledges and support the “good practices identified by WHO and encourages their dissemination within Council of Europe member States”.

The new developments at the UN and CoE level seem promising, first and foremost, for their authoritative interpretation and symbolic relevance. Their new instruments might (and in fact, should) influence future legislation and jurisprudence to include OV among the types of violence against women prohibited by the CEDAW and the Istanbul Convention, recognizing their structural character and therefore encouraging States to tackle their causes and not merely their consequences as biomedical events.

4. A true “Special Care and Assistance”: Activist Perspectives on OV

Civil society and grassroots movements advocating for women’s rights in childbirth and better pregnancy and childbirth care have increased in number and activity in the last two decades, especially after the notion of OV was sanctioned in law. This section aims at giving

an overview of their notion of right to health and care for women in the context of childbirth^{iv}.

First and foremost, the International Federation of Gynecology and Obstetrics (FIGO), which is relevant because, despite being an organization made up of health professionals, it is not weary of using the term “obstetric violence” and it fiercely campaigns against violence against women, including in the context of health facilities. In fact, the FIGO Committee on Safe Motherhood and Newborn Health released a document on Mother and Newborn Friendly Birthing Facilities, including the requisites that a medical facility must meet to be admitted to the worldwide network of “Mother and Newborn Friendly Facilities”. The criteria are: permitting the movement (standing and walking) and the ingestion of food and drinks during the first stage of labor and allowing the woman to position herself the way she feels more comfortable, unless otherwise medically indicated; ensure privacy is provided during labor and birth; possess clear and non-discriminatory guidelines for the treatment of women who are HIV positive and for their newborns, providing them with counseling as needed; allowing at least one person of the woman’s choice to accompany her during labor and birth; providing culturally competent care which is patient-centered, including in the case of perinatal loss; prohibiting all kinds of abuses (physical, psychological, financial) against women before, during and post-partum; offering affordable quality care and be transparent about costs that families and women may incur for childbirth, as well as counseling them on how they might pay; not refusing to provide care for a woman who is unable to pay; avoiding practices which are not evidence-based, such as enemas, shaving, induction of labor, routine episiotomy, separating mother and baby after childbirth, etc.; being prepared for emergencies and for neonatal and maternal resuscitation; encouraging staff to provide pain relief, both pharmacological and non-pharmacological, as needed; promoting skin-to-skin contact right after childbirth; supporting mothers in starting the breastfeeding process. The FIGO document recalls the WHO criteria described in the previous section.

The White Ribbon Alliance (WRA), a network of organizations supporting reproductive, maternal and newborn health and rights, issued “The Universal Rights of Childbearing Women”, a human rights-based document which recalls the main international regulations on dignified, respectful care for mothers and newborns, and transposes such legislation in practical contexts, thus bridging the WHO provisions with their human rights foundation.

Another significant network of civil society organizations working for women’s rights and maternal/reproductive health is the International Childbirth Initiative (ICI), which unites organizations worldwide, including FIGO and WRA and the International MotherBaby Childbirth Organization (IMBCO), together with other partners. The ICI collected the 12 Steps to Safe and Respectful MotherBaby- Family Maternity Care, which also recalls the provisions of human rights instruments and the WHO, promoting a safe, respectful, dignified, affordable, evidence-based healthcare in childbirth, protecting women’s right to informed consent and pain relief, advocating for skin-to-skin contact and lactation, as well as promoting the continuum of support and care in pre- and post-partum.

At the national level, civil society organizations called “obstetric violence observatories” are active in several countries such as Brazil, Argentina, Chile, Spain, Greece, Croatia, and, notably, Italy and Portugal. These organizations’ objective is to map and monitor violations of women’s human rights in childbirth, to lobby at national and international institutions for the recognition of OV as a legal concept and contrast impunity, to raise awareness on the issue of abuse and mistreatment in childbirth in their countries, and to provide information and assistance (even legal) to victims of such violence. They have also raised awareness on how calling a lack of proper care and assistance as foreseen by international human rights

instruments may account for actual “OV”, and not merely to “abuse and mistreatment”, thus making the phenomenon more known and stressing the political potential of language in law and policy in this context (as argued by Katz et al., 2020 and Vacaflor, 2016).

5. Domestic Implementation of Women’s Rights in Childbirth: The Legislative Framework of Italy and Portugal

Both countries have ratified both the CEDAW and the Istanbul Conventions; as for the Oviedo Convention on Human Rights and Bioethics, Portugal is a State Party, while Italy signed in 1997 and never ratified. Both countries are peculiar cases as far as legislation on women’s rights in childbirth is concerned: while Italy does not, to this day, have any legislation on the topic, Portugal adopted a progressive law in 2019.

Such law, n° 110/2019, 09/09/2019, establishes women’s rights drawing upon the WHO recommendations, such as: assistance of one person of choice of the woman during childbirth, even during more invasive procedures (e.g. forceps or vacuum-assisted delivery); the right to be together with the newborn after childbirth; the right to be informed about procedures to be carried out (medical and hygienic); the right to move, stand and walk during the first stages of labor; the right to privacy; the right to be fully informed, to be free from violence and discrimination, to the best attainable standards of care, and to «freedom, autonomy and self-determination», all of the above to be granted within the limits of medical safety. Moreover, the law establishes the continuum of care after childbirth and special attention for vulnerable groups, such cases of stillbirth and perinatal loss.

This law comes after the most recent CEDAW Committee country report, issued in 2015, in which the Committee welcomed “the State party’s significant achievements in reducing infant and maternal mortality” but expressed concern “about the limited freedom experienced by women in their family planning and their choices of birth methods. It is particularly concerned about the reports that women are often subjected to overly medicalized births and caesarean operations without having been consulted beforehand. The Committee is also concerned about the amendments in 2015 to the law on voluntary termination of pregnancy (2007), which impose stringent conditions in the form of four separate obligatory consultations prior to abortion, in addition to fees. The Committee recommends that the State party provide for adequate safeguards to ensure that overly medicalized procedures, such as caesarean operations, for childbirth are thoroughly assessed and carried out only when necessary and with the informed consent of the patient.” The recent law, as progressive as it is, does not refer to the necessity to limit unnecessary C-sections, and no steps forward have been taken in legislation on abortion. The term “obstetric violence” does not appear in the law: this is a relevant aspect, since the medical class is often reticent to recognizing and using the term, perceived as an attack to medical knowledge and authority (See for example Muller Sens and Nunes de Faria, 2019; Junqueira Oliveira and de Mattos Penna, 2017; Marques de Aguiar et al., 2013).

The Associação pelos Direitos da Mulher na Gravidez e Parto (Association for the Rights of Women in Pregnancy and Childbirth, APDMGP) has collected data on childbirth experiences between 2012 and 2015 (see below), testifying to a highly improvable situation. More recently, heated debates have taken place since 2022 between activists and health institutions especially since an increasing number of birthing wards (“maternidades”) are being shut down around the country. The Portuguese Observatory of Obstetric Violence (OVOPortugal, founded in late 2021) and the reproductive justice activist group Saúde Mães Negras e Racializadas em Portugal (Black and Racialized Mothers’ Health in Portugal, founded in 2022), are being active proponents of protests and awareness-raising activities, the latter

having collected data on the proportion of OV against racialized mothers – data that was non-existent to date (see Brito, 2023).

In the case of Italy, the norms governing childbirth are set by the guidelines for physiological childbirth, “Gravidanza fisiologica”, a 2011 document^v issued by the Ministry of Health and the Superior Institute of Health (Istituto Superiore di Sanità, ISS), instructing health professionals on WHO recommended procedures and standards of care in terms of managing complications and informing women on pregnancy and childbirth. The Ministry and ISS also issued informative documents on C-section, prompted by the “alarming rate of non-evidence-based Cesarians” witnessed in Italy (Istituto Superiore di Sanità, 2014). These documents, nevertheless, make no reference to women’s rights in childbirth, neither in terms of standards of care for health professionals, nor in terms of education for pregnant women.

This is despite their multiple references to the concept of “evidence-based practices”; they dedicate no attention to aspects which are not strictly biomedical.

The Italian observatory of OV, OVOItalia, has been active in lobbying for the adoption of a legislation which protects women’s rights in childbirth and recognized OV as a form of criminal offence. Three law proposals have been presented within the Italian parliament on this issue: one on the “promotion of physiological childbirth and the reduction of the C-section rate” - Disegno di Legge (DDL) 2015- 3121 - , one on the “norms for the protection of mother’s and newborn’s rights and for their support before, during, and after childbirth” (recalling procedures recommended and non-recommended by the WHO), and one on the “norms for the rights of the birthing woman and the newborn baby for the promotion of physiological childbirth”, containing the institution of OV as criminal offense (DDL 2016-3670). None of them has been approved as of today, since the status of both proposals is “under committee discussion” since 2017.

The Italian panorama shows that a legislation which recognize the women’s right to health in childbirth does not necessarily prevent breaches of such rights: while criminalizing OV may not be the only way to move forward, more specific measures need to be taken to improve standards of care in childbirth. The Portuguese situation, whose recent law acknowledges the need for *ad-hoc* provisions, but does not mention or criminalize “obstetric violence” as such, will be a testing ground for an alternative way of responding to this emergency without using the term “obstetric violence”, often perceived by the medical class as a means of naming and shaming.

6. Reality Check: Data on OV in Italy and Portugal

It is worth mentioning that a human rights-based approach to health is not the default in many contexts, especially in childbirth; different studies have stressed how medicine seems to be divided between a biomedical paradigm and a holistic, patient-centered one (as in Yamin 2018), which has come to be known as “humanized” in the framework of childbirth rights activism: it is evident that, even in countries where human rights have a historic status and women’s rights are formally acknowledged, this “medical paradigm divide” makes it harder to implement standards of care which are human-rights compliant. This is a necessary remark to introduce and contextualize the data on OV prevalence in Europe, and more specifically in Italy and Portugal, presented below.

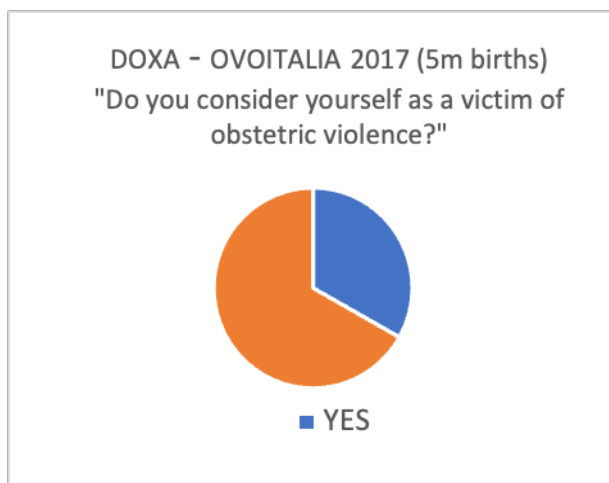
According to the second European Perinatal Health Report documenting changes over 6 years in the health of mothers and babies in Europe, “Healthcare indicators continue to reveal marked variations in the approach to childbirth in Europe. Caesarean section rates range from 14.8% in Iceland to 52.2% in Cyprus, instrumental delivery rates range from 0.5% in

Romania to 16.4% in Ireland, and episiotomy rates range from under 7% in Denmark and Sweden to over 70% in Cyprus and Portugal” (Europeristat, 2010). The current situation shows that medical procedures which are not evidence-based WHO and human rights compliant continue to take place. There figures do not mention the situation of psychological abuses, which are still common according to activists in both Italy and Portugal.

Data on the rate of OV in Italy and Portugal are scarce and exist only thanks to the work of activist movements: the OVOItalia, the Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto (APDMGP), and SaMaNe. In 2023, the latter announced the first dataset on OV in Portugal disaggregated by race (yet unpublished).

In the Italian case, data were gathered and elaborated by Doxa, company specialized in market research, and OVOItalia. The statistics (OVOItalia, 2017) covers a span of time from 2003 to 2017 and includes reports of five million women. It reveals that in Italy, 99% of childbirths occur in medical facilities; the C-section rate is 32% as of 2017; the episiotomy rate reaches 54%, 61% of which with no informed consent; 41% of women declare they were subject to practices harmful to their physical or psychological integrity, and 21% declare they were victims of episodes of OV.

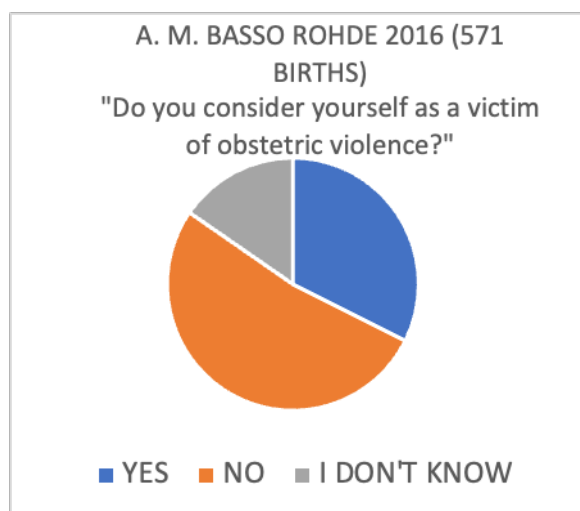
According to a 2013 report by the Italian national Institute for Statistics (ISTAT) the percentage of C-sections (which at the time was the highest in Europe), and in “spontaneous” childbirth medicalization was a serious issue: among vaginal childbirths, 72,2% were medicalized; 22,3% of women declared they were administered oxytocin to speed up contractions (procedure included in the “not recommended” measures by the WHO), while a staggering 14,2% of interviewees was unsure about whether they had been administered oxytocin or not. Standards of care were defined as high in terms of safety and outcomes of childbirth according to the report; this, however, does not imply that women’s human rights in childbirth were respected, as these figures clearly show.



In Portugal, the Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto (APDMGP) developed a study/survey (APDMGP, 2015) comprising the period between 2012 and 2015, including 3833 childbirths. The rate of hospitalized childbirths was 98%; the rate of C-sections amounted to 33,2%. Among vaginal childbirths, 71,1% were medicalized; the episiotomy rate reached 70%; 43,3% of women reported not being involved in informed consent before medical procedures.

While this report refers that 43,5% of women did not have the childbirth they wished for, it does not feature a percentage of women who perceived they had been victims of OV. Therefore, data was extracted by an academic piece of work by Ana Maria Basso Rohde

(2016), who analyzed 571 childbirths in 2016 investigating the perception of mothers about being subject to OV. Only 52,2% of subjects reported that they had not been victims of OV: 32,4% reported having suffered such treatment, and 15,4% responded that they did not know whether they had been victims.



Italian and Portuguese data reveal how, despite the high standards of care guaranteed in human rights instruments and recommended by the WHO, reality is still far from complying with norms and regulations. The highest attainable standard of health is, in many cases, an abstract principle which fades away in the complexities of childbirth care.

The gaps between theory and practice may be due to different factors: lack of information and formation of health personnel, lack of awareness on the part of birthing women, lack of gender-awareness when formulating protocols for childbirth care, use of practices which are not evidence-based, but stem from a “received medical wisdom” dating back to decades ago and never called into question. Best practices as per the WHO recommendations might be hampered if obsolete protocols are not up to date with new scientific evidence, as in the cases where after-birth bonding between mother and newborn baby or the possibility of maternal breastfeeding are neglected on non-scientific grounds.

7. Conclusions

In different States, abuse and ill-treatment during childbirth have been recognized within national jurisdictions as OV (a form of structural^{vi}, gender-based violence) and prohibited. Such laws draw upon international human rights instruments in the framework of guaranteeing a life free from violence for women. As it stands, international human rights instruments recognize a right to “special care and assistance” in childbirth within the framework of the right to health sanctioned by art. 25 UDHR; the definitions of “care and assistance” are necessarily vague in their content, leaving room for State Parties to implement them in detail as they deem feasible and appropriate in their context.

Starting from this basis, this work has illustrated how such care and assistance standards - also articulated in the recommendations of international human rights bodies and the jurisprudence of international human rights courts - may not correspond to what occurs in reality, where birthing women’s bodily autonomy and agency is often left behind even in the presence of the aforementioned protection instruments. Seeking redress in case of violations in international jurisdictions is hard and cumbersome, also because - although this was not

the case in all the cases examined - granting the State's margin of appreciation may result in perpetuating patriarchal patterns that had taken place domestically.

On the other hand, however, international human rights instruments have a strong symbolic significance, and their main goal is to express international consensus and act as frameworks to implement more specific laws at the national level (Khosla *et al.*, 2016). This is why the recent developments in two authoritative international fora (UN General Assembly and within the Council of Europe) are extremely important steps for (1) mainstreaming OV as a form of gender-based violence at the international level, giving this term legal legitimacy and semantic depth, and (2) encouraging governments to act, prompting new legislation and measures protecting women's rights in childbirth (and in general, throughout the whole sexual and reproductive life).

The gap between the amount of care guaranteed by human rights instruments and the care experienced by women giving birth in the world and, more specifically, in Italy and in Portugal, is present and significant; more work needs to be done by institutions (be it international organization or governments at the domestic level) and medical entities, together with efforts already ongoing by civil society organizations, to make clear that OV is a violation of women's human rights; they must work for its prevention and elimination, given that previous advocacy efforts have proven effective (see the developments at the UN and CoE level).

Future research might explore the following paths: looking at how to integrate local best practices related to one single medical facility with domestic law and new international (European) standards; monitoring and investigating the Portuguese context, to analyze any impact of the new 2019 law on childbirth care; monitoring and investigating the Italian context, to analyze how maternal care can be improved without any legal instrument outlawing OV; investigating whether and how there could be case law at the ECtHR level including cases where OV is explicitly mentioned, following the last developments; investigating how gender and power interplay in the case of transgender people giving birth, whether and with what patterns OV would occur.

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childbirth is possible, without obtaining voluntary, expressed, and informed consent from the woman.” See *Ley Orgánica sobre el derecho de la Mujer a una Vida Libre de Violencia*, art. 15

ⁱⁱ A legal proposal to specifically criminalize “obstetric violence” was put forward in Portugal in late 2021 by MP Cristina Rodrigues, but, having caused the same controversies that occurred in Italy in 2017, it has not been approved.

ⁱⁱⁱ This does not imply that other human rights systems, such as the African or the Inter-American one, are not relevant; however, this work’s reach is limited to the systems relevant to Italy and Portugal.

^{iv} The organizations mentioned in this paragraph do not constitute an exhaustive list: this work focuses on the ones that made an impact or are relevant to the process of prevention and elimination of obstetric violence.

^v According to the document, the next update to the 2011 version had to take place in 2014. There has been no update since the 2011 version. See Istituto Superiore di Sanità, 2011.

^{vi} Studies have reported the structural dimension of obstetric violence, indicating that it stems from norms and values deeply embedded in society and pervading other realms of social life. See Sadler et al., 2016; Dos Santos Simões, 2016.