Edited by
Marilisa D'Amico,
Costanza Nardocci

OB-GYN VIOLENCE

Italy, Europe, and Canada

IDN
I DIRITTI NEGATI

RICERCHE

FrancoAngeli

COLLANA DIRETTA DA
GUSTAVO ZAGREBELSKY
MARILISA D'AMICO

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Collana diretta da
Gustavo Zagrebelsky
e Marilisa D'Amico

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Obstetric and Gynaecological Violence as a Form of Gender-based Violence

Giussy Barbara, Laila Micci, Edgardo Somigliana

Summary: 1. Introduction – 2. The Institutional context – 3. Should obstetric and gynaecological violence be considered a specific form of gender-based violence? – 4. Conclusions.

1. Introduction

Violence against women is a form of gender-based violence perpetrated against women on the basis of their gender or that has a disproportionately adverse impact on women. In accordance with the Istanbul Convention (Article 3) the term 'gender' shall be understood to refer to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men[1]. Violence against women refers to all forms of gender-based violence that result in or are likely to result in physical, sexual, psychological, or economic harm or suffering to women. This includes, but is not limited to, threats of such acts, coercion, or arbitrary deprivation of liberty, whether they occur in public or private life. This is precisely the definition set forth by the Declaration on the Elimination of Violence against Women in 1993[2].

1. The Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention), Council of Europe, Instanbul May 2011. Available at: *https://www.coe.int/en/web/conventions/full-list?module=treaty-detail&treatynum=210* (Accessed October 2024).

2. United Nation, Declaration on the Elimination of Violence against Women: resolution / adopted by the General Assembly, UN. General Assembly (48th

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Obstetric and gynaecological violence can be defined as any disrespectful or abusive behaviour towards women perpetrated by health professionals when providing sexual and reproductive health services. This involves a wide range of different procedures, including obstetric care during pregnancy, assistance with childbirth, breastfeeding counselling, gynaecological examinations, abortions, medically assisted procreation, and contraceptive prescription. It also includes non-medically necessary procedures that may be harmful, forced medical acts and/or medical acts performed without consent[3,4,5].

The term "obstetric and gynaecological violence" is a relatively recent concept. Furthermore, women who have been subjected to obstetric and gynaecological violence may also experience difficulties in recognising and labelling this form of abuse. However, in recent years, there has been a notable increase in awareness-raising initiatives by civil society organisations, contributing to a growing understanding of this specific type of violence. The majority of initiatives have concentrated on the issue of obstetric violence, with relatively limited information available on initiatives addressing gynaecological violence.

The question arises as to whether obstetric and gynaecological violence can be considered a specific form of gender-based violence, and thus sexist in nature, and whether reflects a patriarchal culture that continues to exert a dominant influence in society, including the medical field. The purpose of this chapter is therefore to provide an overview of how (and whether) the phenomenon of obstetric and

sess.: 1993-1994). Available at *https://digitallibrary.un.org/record/179739?v=pdf* (Accessed October 2024).

3. R. Jewkes, L. Penn-Kekana, *Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence against Women*, in *PLoS Med.*, 2015 Jun 30; 12(6):e1001849. DOI: 10.1371/journal.pmed.1001849. PMID: 26126175; PMCID: PMC4488340.

4. J.M. Martínez-Galiano, J. Rodríguez-Almagro, A. Rubio-Álvarez, I. Ortiz-Esquinas, A. Ballesta-Castillejos, A. Hernández-Martínez, *Obstetric Violence from a Midwife Perspective*, in *Int J Environ Res Public Health*, 2023 Mar 10; 20(6):4930. DOI: 10.3390/ijerph20064930. PMID: 36981838; PMCID: PMC10049399.

5. WHO, *The prevention and elimination of disrespect and abuse during facility-based childbirth*, September 2014. Available at: *https://iris.who.int/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf* (accessed October 2024).

gynaecological violence can be situated within the broader context of gender-based violence. It will provide a summary of the positions of various societies and political organisations that have addressed this issue, while also providing insights into aspects that remain unclear, controversial or subject to ongoing debate.

2. The Institutional context

Both the United Nations (UN) General Assembly and the European Parliament have acknowledged the existence of obstetric and gynaecological violence as a specific form of gender-based violence[6,7].

In particular, the UN General Assembly on violence and mistreatment against women in reproductive health services specified that the definition of violence against women, as delineated in Article 1 of the Declaration on the Elimination of Violence against Women, is applicable to Obstetric violence.

In Resolution No. 2306 of the Parliamentary Assembly of the Council of Europe on Obstetrical and Gynaecological Violence, adopted in 2019, obstetric violence is clearly defined as a form of gender-based violence. This form of violence has long been hidden and is still too often ignored. The document concludes by emphasising that instances of gynaecological and obstetric violence serve to illustrate the existence of significant gender inequalities, whereby the voices of women are not given sufficient consideration[8].

6. United Nations General Assembly, *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*, A/74/137; Distr.: General 11 July 2019. Available at: *https://digitallibrary.un.org/record/3823698?v=pdf* (accessed October 2024).

7. European Parliament, *Sexual and reproductive health and rights in the EU, in the frame of women's health*, P9_TA(2021)0314. 24 June 202. Available at: *https://www.europarl.europa.eu/doceo/document/A-9-2021-0169_EN.html* (accessed October 2024).

8. Council of Europe Parliamentary Assembly, *Resolution 2306: Obstetric and Gynaecological Violence*, 2019. Available at: *https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28236* (accessed October 2024).

In the report of the Special Rapporteur on "Violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence," the United Nations General Assembly has identified a number of gender stereotypes as the root causes of obstetric and gynaecological violence[9]. These include, for example, discriminatory national laws or practices that require spousal or third-party consent for women's medical treatment, effectively denying their right to make decisions about their own health care. Such laws contribute to the abuse and violence that women may experience in the context of reproductive health services.

In addition, there are several examples of harmful gender stereotypes related to reproductive health that limit women's autonomy and agency. Such stereotypes include beliefs about women's decision-making power, natural role in society, and motherhood. The perpetuation of destructive gender stereotypes related to reproductive health, including the notion that women are innately less competent to make decisions, that their role in society is naturally subordinated to that of men, and that motherhood is their sole purpose, collectively affect women's autonomy and agency. Such stereotypes arise from deeply rooted religious, social, and cultural beliefs and ideas about sexuality, pregnancy, motherhood, perceptions of femininity, and in some cases (particularly in the context of obstetric care) may be further reinforced by the notion that childbirth is a naturally painful experience for women. Women are encouraged to express joy at the birth of a healthy infant, while their own physical and emotional well-being is frequently overlooked. The UN report also recognize that deficiencies and limitations in the health system can also be identified as the fundamental drivers of mistreatment and violence against women during childbirth. The inadequate working conditions

9. D. Simonovic, UN. Human Rights Council. Special Rapporteur on Violence against Women and Girls, its Causes and its Consequences; UN. Secretary-General. A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence: note / by the Secretary-General. 2019. Available *at https://digitallibrary.un.org/record/3823698?v=pdf* (accessed October 2024).

experienced by many health professionals, coupled with the historical over-representation of men in the health workforce, is in stark contrast with the obligation of states to ensure the accessibility, quality and availability of maternal health-care services, facilities and trained professionals, as well as to ensure gender equality among healthcare providers.

The "European Parliament Resolution on sexual and reproductive health and rights" adopted in 2021, identifies gynaecological and obstetrical violence as a form of sexual and reproductive health abuse, discrimination, and human rights violation motivated by gender hatred. The European Parliament calls upon the Member States to implement measures that guarantee access without discrimination to high-quality, accessible, evidence-based, and respectful maternity, pregnancy, and birth-related care. This should be done in accordance with the standards set forth by the World Health Organization. Laws, policies and practices that exclude certain groups from access to maternity, pregnancy and childbirth-related care should be reformed. This requires the elimination of discriminatory legal and policy restrictions based on sexual orientation or gender identity, nationality, racial or ethnic origin and migration status. Moreover, the Member States are urged to take all feasible steps to ensure that women's rights and dignity are respected in childbirth. Furthermore, they are called upon to unequivocally denounce and eradicate all forms of physical and verbal abuse, including gynaecological and obstetric violence, as well as any other associated gender-based violence that may occur during the antenatal, childbirth and postnatal care periods. Such violence violates women's human rights and may constitute forms of gender-based violence. The European Parliamentary Assembly reaffirms its commitment to the promotion of gender equality in all areas, which will facilitate the prevention and eradication of all forms of violence against women, including obstetrical and gynaecological violence.

In April 2024, the European Parliament Committee on Women's Rights and Gender Equality (FEMM) identified the issue of obstetric and gynaecological violence as being situated at the convergence of two structural crises: gender-based violence and the under-resourcing of

healthcare systems. It can be argued that there are two key factors that contribute to the phenomenon of obstetric violence. The first can be linked to the evolution of medicine, in which there has been a tendency to pathologize women's bodies and to pursue a biomedical approach. The second factor is not the result of deliberate actions, but rather is embedded within the structure of the medical system[10]. From the perspective of the FEMM Committee, it is of the utmost importance to conceptualise obstetric and gynaecological violence as a systemic phenomenon. This approach is essential to facilitate recognition of its nature as a gender-based form of violence and to acknowledge that such acts are not always deliberate, but shaped by structural deficiencies inherent to healthcare systems.

In accordance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), particularly Article 12, it is mandatory for governments to implement comprehensive measures to eradicate discrimination against women in the domain of healthcare. This encompasses access to family planning services and all matters pertaining to pregnancy, childbirth and the postpartum period. Health services must guarantee women's prior informed consent, support their dignity, safeguard their privacy and consider their needs, perspectives and autonomy[11].

On the other hand, the Istanbul Convention of the Council of Europe does not explicitly delineate obstetric violence as a distinct form of violence against women. Despite the absence of explicit mention of obstetric violence as a form of gender-based violence, the Istanbul Convention includes forced marriage, female genital mutilation, forced abortion, and sterilisation within its scope.

10. European Parliament's Committee on Women's Rights and Gender Equality (FEMM), *Obstetric and gynaecological violence in the EU - Prevalence, legal frameworks and educational guidelines for prevention and elimination*, April 2024. Available at: *http://www.europarl.europa.eu/supporting-analyses* (accessed October 2024).

11. UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, December 18, 1979, United Nations, Treaty Series, Vol. 1249. Available at: *https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf* (accessed October 2024).

3. Should obstetric and gynaecological violence be considered a specific form of gender-based violence?

Over the course of centuries, childbirth and motherhood have been regarded as a duty for women, rather than as one of numerous potential roles. It was expected that women would contribute to society by reproducing and dedicating themselves to their families, husbands, and children.

These stereotypes have their roots in deeply entrenched religious, social, and cultural beliefs and ideas about femininity, sexuality, pregnancy, and motherhood. Such damaging stereotypes – in the context of the phenomenon of obstetric violence - are often reinforced by the assumption that childbirth should be a painful experience for women. The Bible phrase "with pain you will give birth" is emblematic of this pervasive societal mindset.

The focus is frequently on the health of the infant, with minimal consideration given to the mother's physical and emotional well-being. Maternity services are not immune to patriarchal influences. Women are encouraged to express positive sentiments about a healthy infant, while their own physical and emotional health is often undervalued.

Starting from these considerations, it can thus be argued that obstetric violence may constitute a form of gender-based violence that emerges from a patriarchal perspective of society, characterised by the subordination of women and the privileged status of men. This subordination can be observed in a number of different contexts, including both public and private spheres.

A significant proportion of instances of obstetric and gynaecological violence can be classified as gender-based violence.

1) Firstly, as some authors have suggested, to date no cisgender man has given birth. This indicates that the violence in question not only affects women disproportionately, but also exclusively[12].
2) Secondly, the lack of respect for women's equality and human rights,

12. S. Lévesque, A. Ferron-Parayre, *To Use or Not to Use the Term "Obstetric Violence": Commentary on the Article by Swartz and Lappeman*, in *Violence Against Women*, 2021, 27(8), 1009-1018. *https://doi.org/10.1177/1077801221996456*.

which can be identified as one of the primary causes of obstetric and gynaecological violence, represents a significant contributing factor to the phenomenon of violence against women in general. This suggests that there may be a common underlying cause of obstetric violence and gender-based violence.

3) Thirdly, patient-caregiver interactions frequently entail unequal power dynamics, where the caregiver possesses knowledge and authority over the patient, who is situated in a vulnerable position. This power imbalance, which is also characteristic of acts of gender-based violence, can result in the woman being placed in a submissive position.

However, the topic under consideration appears to be extremely complex, and, according to the authors, categorizing obstetric violence as a mere form of gender-based violence may not necessarily ensure an exhaustive analysis of the phenomenon, which is crucial to facilitate the development of effective solutions. This is because there are multiple factors that contribute to the intricate nature of the subject matter.

First of all, as already mentioned, it seems appropriate to conceptualise obstetric violence not merely in terms of the relationship between the individuals involved, but instead in terms of the relationship between the systems involved. In this case, it is essential to recognise the ways in which health and cultural systems interact and to understand the potential influences within them, which may, of course, have a sexist and gender-based component. However, reducing these influences to this one factor would be a limitation of the analysis.

Furthermore, it is also important to note that the healthcare professionals who perpetrate obstetric and gynaecological violence against women are not exclusively male (for instance, midwives are mostly women). Indeed, they are also more often female. In such instances, it becomes more challenging to discern the sexist and gender-based aspects of violent and disrespectful conducts during obstetrical and gynaecological procedures.

Moreover, it is crucial to recognise that the term "obstetric and gynaecological violence" should be regarded as an umbrella term that

encompasses a wide range of practices that are challenging to categorise within a single typology. The experiences and emotions that women have in relation to these violent experiences can also vary significantly[13]. Some women may experience feelings of dehumanisation, disrespect, or abuse, reporting instances of care that was insensitive and rude, which has resulted in increased psychological and emotional suffering. Such instances include cases in which patients have been made to feel insignificant, received dismissive comments regarding their pain, or been judged based on their age or body size. On the other hand, some women experienced instances of physical violation, including non-consensual cutting during childbirth or non-consensual insertion of fingers into the vagina. In these cases, women reported feelings of powerlessness and coercion, accompanied by a sense of impotence due to being uninformed or misinformed about the medical interventions performed.

Obstetric violence can manifest in various forms, including intentional or deliberate physical abuse (active forms), unintentional neglect due to staff shortages or overcrowding (passive forms), and issues related to the conditions of the healthcare system, such as for example a lack of beds that compromises basic privacy and confidentiality.

Nevertheless, all these various modalities have the potential to impact women's health, their experience of childbirth, and their right to respectful, dignified, and humane care. Pregnancy and childbirth are experiences that are unique to each woman and which have the potential to leave a profound and enduring impact on her life.

The central issue is whether it is appropriate to consider all the several different forms of obstetric and gynaecological violence as gender-based, or whether this characterisation is applicable only to some of them. In other words, is it possible to conclude that all practices within the domain of obstetric and gynaecological violence are inherently sexist in nature?

13. H. Keedle, W. Keedle *et al.*, *Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years*, in *Violence Against Women*, 2024, Jul; 30(9):2320-2344. DOI: 10.1177/10778012221140138. Epub 2022 Nov 30. PMID: 36452982; PMCID: PMC11145922.

In order to provide a systematic classification of the various practices that may fall under the category of "obstetric and gynaecological violence" and to ascertain whether they can be considered forms of gender-based violence, a classification of the main harmful practices reported in the literature has been proposed (see *Figure 1*). It should be noted that this classification is not intended to be exhaustive, and that the categories presented may overlap.

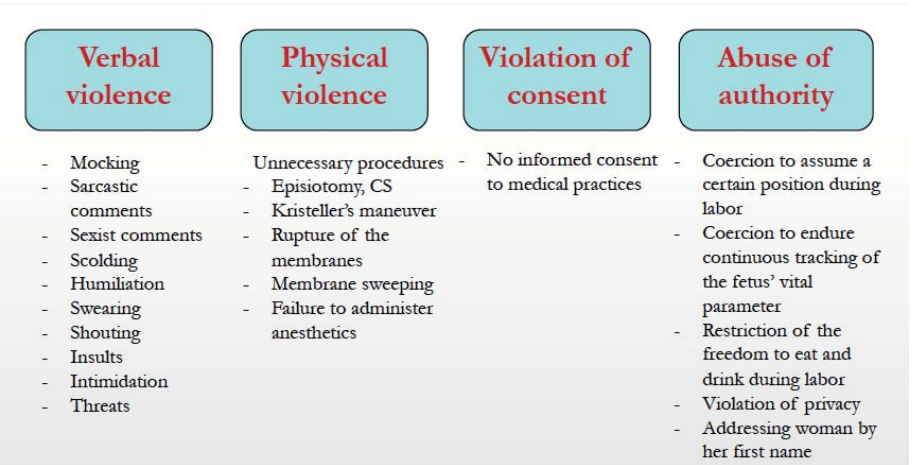

Fig. 1 – Classification of practices of Obstetric and Gynaecological Violence

In accordance with the proposed classification, four distinct categories of obstetric and gynaecological violence may be identified.

1) Acts of *Verbal violence*, defined as the use of words or language with the intention of inflicting emotional or psychological harm on another individual. This form of violence encompasses a range of behaviours, including mocking, sarcastic comments, sexist remarks, scolding, humiliation, swearing, shouting, insults, intimidation, threats, and other forms of verbal aggression in relation to situations of obstetric and/or gynaecological care.
2) Acts of *Physical violence* that are identified as causing suffering to women during childbirth, such as the performance of unnecessary surgical incisions (episiotomy, caesarean section), the application of Kristeller's manoeuvre, the detachment and rupture of the membranes, and the application of pressure to the abdomen.

The role of effective communication between professionals and women in this process appears to be a crucial contributing factor to the problem. Additionally, instances of omission that result in the woman experiencing pain are also included in this category. These instances include for example the failure to administer anaesthetics and painkillers.

3) Acts related to a "*Violations of consent*", referring to any procedures undertaken without prior, informed consent. At the time of admission for delivery, an informed consent is not requested. This may be viewed as an attempt to women's power, considering in particular that there is an alternative for delivery, i.e. a caesarean section. The decision on the mode of delivery (vaginal or caesarean) should be an informed decision of the woman.
4) Acts of "*Abuse of authority*", referring to a range of actions that may be perceived by women as oppressive or controlling, particularly in the context of healthcare. Such actions may include paternalistic medicine, coercive measures during the expulsive phase, limitations on the birthing mother's autonomy and ability to eat food during labour, and violations upon her privacy.

In consideration of the aforementioned distinctions between various forms of obstetric violence and their disparate emotional consequences, and returning to our initial question, it is thus pertinent to classify all these acts of obstetric and gynaecological violence as gender-based? Is it appropriate to make generalisations rather than distinguishing between specific situations?

It is the author's opinion that a one-size-fits-all approach is inappropriate in this context, and that not all forms of obstetric and gynaecological violence should be considered gender-based. Such an approach is of no benefit to women in their understanding and overcoming of the experiences they have undergone. Similarly, it is of no benefit to health professionals or policymakers in the development of effective strategies to address this harmful phenomenon. Furthermore, it may foster a sense of distrust in the healthcare system.

Unquestionably, it is possible to identify instances of obstetric and gynaecological violence that are based on gender violence. Such acts

frequently entail the utilisation of sexist language, verbal aggression, misogynistic attitudes, forced sterilisation, mutilation, denial of abortion, denial of a requested caesarean, a dearth of respect for women's equal status and medical paternalism. In Western countries, there is also the spread habit to host the partner in the box for the delivery, in most cases without requesting women's view. It is given for granted that the partner should assist. These elements are indicative of a pattern of victimisation that is typically experienced by women.

In contrast, institutional violence in the context of maternity care can be defined as violence perpetrated by healthcare professionals as a result of systemic issues, namely overwork, lack of privacy and insufficient time devoted to patients. It is important to note that this form of violence is not gender-based in nature.

A third area of concern is the phenomenon of medical malpractice, which can occur in instances where there is an inadequate informed consent to medical procedures – even when performed correctly – or when a procedure is conducted without a legitimate medical justification. Additionally, in such cases, instances of obstetric violence are not inherently gender-based.

It is important, in the author's view, to exercise caution when generalising and categorising obstetric violence as a mere form of gender-based violence. This is because different forms of obstetric violence may require different approaches.

In order to effectively address gender-based violence in obstetric settings, which undoubtedly exists, it is essential to implement policies that guarantee gender equality, challenge gender stereotypes, empower women and, most importantly, provide comprehensive training for healthcare professionals on gender and equity issues.

Conversely, in the context of institutional violence, it is necessary to prioritise the organisation of maternity facilities at the management level. This should entail addressing a range of health system issues, including understaffing, high patient volumes, low salaries, long working hours and a lack of infrastructure. In addition, there is a need to promote the importance of respectful care as an essential component of quality care. On the other hand, in the context of medical malpractice, the training of healthcare professionals, the use of only medically justified procedures,

and the importance of shared decision-making and informed consent are pivotal.

Furthermore, when addressing the issue for obstetric violence, searching for solutions, it is crucial to acknowledge the potential resistance of healthcare professionals to using the term "violence," including forms of gender-based violence, as it might imply a deliberate act of violence perpetrated by healthcare providers[14]. It is important to acknowledge that instances of mistreatment may be attributed to underlying systemic issues, a lack of training, misunderstanding, malpractice, or even negligence, as distinct from intentional violence. The implementation of effective strategies may be complicated by the fact that the term "violence" is often perceived as taboo by healthcare providers, and this can lead to resistance. This is due to the fact that the term is frequently employed in a manner that is perceived as offensive, which consequently results in its avoidance.

In addition, it seems pertinent to briefly address two contemporary forms of obstetric violence that can undoubtedly be attributed to gender-based inequality.

The first of these forms entails the denial or obstruction of access to legal abortion, which can ultimately result in harm to women or the performance of unsafe, illegal abortions[15]. Despite recent legislative developments in some countries that have expanded access to abortion, it remains illegal or subject to significant restrictions in numerous locations. In Italy, where legal abortion is guaranteed by legislation, women in some regions have limited access to the procedure due to a lack of hospitals that provide it. The criminalisation of abortion serves to reinforce patriarchal norms that penalise women for rejecting motherhood.

The second form concerns the practice of caesarean section on maternal request, in the absence of a medical indication. This raises the question of whether the refusal of a caesarean section on maternal request could be regarded as a form of gender-based obstetric violence,

14. F.A. Chervenak *et al.*, *Obstetric violence is a misnomer*, in *American Journal of Obstetrics & Gynecology*, Vol. 230, Issue 3, S1138-S1145.

15. E. O'Brien *et al.*, *Obstetric violence in historical perspective*, in *The Lancet*, Vol. 399, Issue 10342, 2183-2185.

and of whether this is a method of penalising women who decline natural childbirth.

4. Conclusions

From the author's perspective, it is an insufficient and inaccurate characterization of obstetric and gynaecological violence to view it as a mere form of gender-based violence. It would be inexact to claim that all instances of obstetric violence are rooted in sexism; this would be a reductionist view and an insufficient explanation of a complex phenomenon.

It is of the utmost importance to distinguish between the different forms of obstetric violence in order to develop targeted and effective solutions for each specific case. This necessitates a clear delineation between gender-based violence, institutional violence and medical malpractice.

It is evident that initiating a constructive and informed dialogue with healthcare professionals on the subject of gender stereotypes and the necessity of compassionate care is of paramount importance. Moreover, it is of the utmost importance to respect the principle of women's autonomy and to maintain a balance between this principle and the principle of beneficence, which also encompasses the foetus.