STUDY

Requested by the FEMM committee

European Parliament

Obstetric and gynaecological violence in the EU - Prevalence, legal frameworks and educational guidelines for prevention and elimination

Policy Department for Citizens' Rights and Constitutional Affairs
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Obstetric and gynaecological violence in the EU - Prevalence, legal frameworks and educational guidelines for prevention and elimination

Abstract

This study presents an overview of how the issue of obstetric and gynaecological violence is currently being apprehended in the EU. Based on research carried out across the EU 27 Member States, it identifies issues and challenges; looks at the legal framework currently applicable to this form of violence; examines ongoing political and legal developments; and gathers initiatives carried out at the national level to improve understanding and prevention of this form of gender-based violence by healthcare professionals and society in general. Finally, it provides recommendations for different stakeholders.

This document was requested by the European Parliament's Committee on Women's Rights and Gender Equality (FEMM).

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LIST OF ABBREVIATIONS

ASD	Post-partum acute stress disorder
BMI	Body Mass Index
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSO	Civil society organisation
EBCOG	European Board and College of Obstetrics and Gynaecology
EIGE	European Institute for Gender Equality
EMA	European Midwives Association
ERRC	European Roma Rights Centre
EU	European Union
FIGO	International Federation of Gynaecology and Obstetrics
FRA	European Agency for Fundamental Rights
GA	Gestational age
GP	General practitioner
IPPF	International Planned Parenthood Federation
LGBT	Lesbian, gay, bisexual, transgender
MS	Member State
NAP	National Action Plan
NGO	Non-governmental organisation
OBGYN	Obstetric and Gynaecologic
PACE	Parliamentary Assembly of the Council of Europe
PPD	Post-partum depression
PTSD	Post-traumatic stress disorder
SAAGE	Scientific Analysis and Advice on Gender Equality in the EU
STI	Sexually transmitted infection
UN	United Nations
VAW	Violence Against Women
WHO	World Health Organisation

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EXECUTIVE SUMMARY

This study presents an overview of how the issue of obstetric and gynaecological violence is currently being apprehended in the EU. Drawing upon concrete quantitative and qualitative evidence from available data, studies and analysis from various publicly available sources (EU and Member States policy reports, academic articles, CSOs documents, professional organisations, etc.), the research carried out across the 27 EU Member States aimed to assess the current understanding and awareness of the issue, the way it is (or is not) legally framed in Member States and to identify initiatives implemented at national level to improve the understanding of this form of gender-based violence by healthcare professionals and society in general. Finally, on the basis of the identified issues and challenges, the study developed some recommendations for different stakeholders.

Obstetric and gynaecological violence encompasses multiple forms of harmful practices perpetrated during obstetric and gynaecological care. These practices are considered violent because of their structural nature; that is, they are the result of an organisational context that facilitates the emergence and sustenance of patterns of violent and abusive behaviours within healthcare facilities.

Obstetric and gynaecological violence is situated at the convergence of two structural crises: gender-based violence and the under-resourcing of healthcare systems and institutions. The former has been inseparable from the development of medicine as an institution through the pathologisation of women's bodies and their biomedicalisation. The latter is evidence that obstetric and gynaecological violence is not always intentional, but instead, embedded in the structure of the medical system.

At the time of this study, there are no systematic data collection processes in place, and existing studies carried out in some Member States apply different approaches with varying definitions and terminology to report on the prevalence of, mostly, specific sub-types of obstetric violence. Nevertheless, studies identified in this study showcase a variety of forms of violence and their scale. Adding to the prevalence of this violence are institutional structures (such as the organisation of private and public hospitals) and the impact of COVID-19, which shed light on often hidden forms of obstetric and gynaecological violence, and in many cases contributed to exacerbating them.

Given obstetric and gynaecological violence is not recognised by national law in any EU Member State (whether as a general women's human rights violation, a violation of specific women's reproductive health rights or a specific form of gender-based violence), victims seeking redress must rely on pre-existing legal instruments. Examples of these include patient rights or minimum standards of healthcare, and among those, few include obstetric and gynaecological treatments expressly.

Since obstetric and gynaecological violence is a relatively new concept, research has shown that women who have experienced it often face difficulties to name and understand it as such. However, across the EU, a number of initiatives have developed through social networks to collect women's testimonies (with the emergence of transnational movements), which have contributed to placing the issue on the societal agenda. Recently, legislative proposals have been put forward to push for a better legal recognition of the issue, while in some Member States, the issue has been integrated in national and/or regional strategic policy documents on gender equality.

Data collection carried out at EU and Member State level has shown that overall, healthcare professionals are resistant to frame the issue of obstetric and gynaecological violence as a form of systemic gender-based violence. However, some initiatives have been taken to improve healthcare professionals' understanding of the issues at stake (including professional guidelines, protocols for healthcare professionals - sometimes developed by healthcare professionals themselves - to raise awareness on obstetric and gynaecological violence, harmful practices, etc.), or to foster positive

changes in their work (including training and capacity building to help them adopt a more gender-sensitive approach to their work and transform normalised practices).

Based upon the issues and challenges identified in this research, the study proposes a set of recommendations aiming at improving understanding and recognition of obstetric and gynaecological violence; fostering better access to justice and reparation; and improving prevention and the provision of more respectful care to all women.

1. INTRODUCTION

This study presents an overview of how the issue of obstetric and gynaecological violence is currently being apprehended in the EU. Drawing upon concrete quantitative and qualitative evidence from available data, studies and analysis from various publicly available sources (EU and Member States policy reports, academic articles, CSOs documents, professional organisations, etc.), the research carried out across the 27 EU Member States first sought to gauge the level of awareness of the issue, and how it has been legally framed in the different Member States. It explored some of the avenues for reparation and redress accessible to victims and looked at the initiatives implemented at national level to improve the understanding of this form of gender-based violence by healthcare professionals and society in general. Finally, on the basis of the identified issues and challenges, some recommendations for different stakeholders were developed to prevent and address this form of violence.

1.1. Methodology

The research team first carried out a number of interviews with EU and international stakeholders to collect information on the broad political context and issues at stake in relation to obstetric and gynaecological violence[1].

Further on, EU and international data and information were collected and reviewed, including legal and policy documents, academic publications as well as publications issued by non-institutional actors, such as CSOs and pan-European associations and federations. The data collection exercise was carried out at the Member State level to obtain some information on the prevalence and awareness of the issue and potential policy/sector initiatives implemented to address it.

Based upon the findings from this research, a number of interesting developments were identified in six Member States (Belgium, Spain, Croatia, Poland, Portugal, Sweden) in which additional research was carried out. Those case studies provided more details on relevant legislation, policies or initiatives developed to improve the response to this widespread form of gender-based violence[2].

Finally, the data generated through desk research was triangulated, analysed and synthesised in order to provide a mapping and comparative overview of the situation in the 27 EU Member States, trends in relation to the key issues identified, and concrete recommendations.

1.2. Key challenges in collecting and analysing the data

The review of the information collected in the 27 EU Member States showed significant differences in the ways obstetric and gynaecological violence has been understood, acknowledged and addressed by institutional and professional stakeholders throughout Europe. The issue has not benefited from the same level of interest in all EU MS, and therefore, in several countries, information on this phenomenon is limited. In others, although the issue is addressed by some non-institutional stakeholders (e.g. civil society organisations), limited information is provided on the issue at national level and on potential initiatives carried out to address the phenomenon.

In addition, there is no commonly used or agreed definition of obstetric and gynaecological violence, so when researching for initiatives addressing the issue, researchers collected a wide range of information that was not easily comparable.

In countries where information specifically addressing obstetric and gynaecological violence is lacking, researchers had to expand the scope of their research to issues not directly related to the phenomenon

[1] See Annex 3 for a list of those interviews.

[2] Examples from those cases studies are presented in boxes throughout the study, and the case studies are presented in Annex 1.

(e.g. perinatal health), collecting interesting information but also bringing in an additional layer of complexity to the objective of collecting comparable data.

The main issue thus relates to how comparable such diverse information can be. In each section, the research team has tried to adopt a comparative lens as far as possible. However, given the diverse nature and scope of the information collected across the MSs, the comparative analysis remains limited.

1.3. Structure of the study

The study is structured as follows:

- **Section 2** outlines the conceptual framework around obstetric and gynaecological violence. By examining the legal and policy context in which this issue has emerged, it highlights some of the current challenges in naming and defining the phenomenon and its causes.
- **Section 3** presents an overview of the existing data on the prevalence of certain forms of obstetric and gynaecological violence that were collected through research and surveys at Member State level. It also gives an overview of the existing research carried out on specific groups of women who are most at risk and identifies important data gaps and issues in obtaining comparable data at EU level.
- **Section 4** provides an overview of the initiatives that are being carried out by civil society organisations in Member States to raise awareness of the issue and collect women's testimonies.
- **Section 5** provides an overview of how Member States' decision-making institutions have addressed the issue. It presents the current legal framework and political debate in the Member States, highlighting current gaps and showcasing recent positive evolution towards a better consideration of the issue.
- **Section 6** presents some of the existing judicial and extra-judicial mechanisms that can allow women access to redress and reparation, followed by the problems and barriers they encounter to do so. This section also highlights the role of civil society organisations in providing alternative spaces for women to denounce this violence and initiatives to foster better access to justice.
- **Section 7** reviews how healthcare professionals have addressed the issue of obstetric and gynaecological violence across Member States and their resistance to the issue. It also presents some initiatives taken to improve understanding of the issue and to foster improved obstetric and gynaecological care identified in some of the Member States.
- **Section 8** presents the conclusions and recommendations derived from this study.

2. UNDERSTANDING OBSTETRIC AND GYNAECOLOGICAL VIOLENCE

Key findings

Since the term gained traction, defining obstetric and gynaecological violence, and outlining what it encompasses, has become a serious challenge.

Psychological, physical and sexual abuse during obstetric and gynaecological consultations; forced medical acts or medical acts performed without consent; non-medically necessary (harmful) procedures; or refusal or delay of care are issues that have been defined as constitutive of obstetric and gynaecological violence. The consequences of obstetric and gynaecological violence can severely impact on women's physical, mental and social health.

As a social and systemic phenomenon, obstetric and gynaecological violence is situated at the convergence of two structural crises: discrimination based on gender and the under-resourcing of healthcare systems and institutions.

Understanding obstetric and gynaecological violence as systemic is necessary not only for understanding it as a form of gender-based violence, but also for recognising that these acts are not necessarily intentional and that they are a product of structural issues concerning healthcare systems.

2.1. Defining obstetric and gynaecological violence

Obstetric and gynaecological violence encompasses multiple forms of harmful practices perpetrated during obstetric and gynaecological care. While obstetric violence may be suffered during pregnancy, childbirth and post-partum, women might experience gynaecological violence during gynaecological consultations throughout their lives. These practices are considered violent because of their structural nature; that is, these practices are the result of an organisational context that facilitates the emergence and sustenance of patterns of violent and abusive behaviours within healthcare facilities.

Although there is no consensus on the definition of obstetric and gynaecological violence, the following list details the forms that have been identified as such, on the basis of previous research:

- **Psychological, physical and sexual abuse during obstetric and gynaecological consultations** – these include humiliating behaviours such as being denied privacy[3]; physical abuse; coercion, such as restricted movement[4] or no choice of birth position[5]; non-consensual

[3] Limmer C. M., Stoll K., Vedam S., Leinweber J., & Gross M. M. Measuring Disrespect and Abuse During Childbirth in a High-Resource Country: Development and Validation of a German Self-Report Tool, Midwifery, 2020, https://doi.org/10.1016/j.midw.2023.103809

[4] Mena-Tudela D., Iglesias-Casás S., González-Chordá V.M., Cervera-Gasch Á., Andreu-Pejó L., Valero-Chilleron M.J. Obstetric Violence in Spain (Part II): Interventionism and Medicalization during Birth, International Journal of Environmental Research and Public Health, 2021; 18(1):199, https://doi.org/10.3390/ijerph18010199

[5] Limmer C. M. M.et al., Measuring Disrespect and Abuse During Childbirth in a High-Resource Country: Development and Validation of a German Self-Report Tool.

vaginal or rectal penetration for medical examinations; discrimination/neglect/not being treated with dignity during pregnancy and gynaecological consultations[6]; infantilisation[7]; verbal abuse such as staff making inappropriate comments; ridiculing them and/or raising their voice[8, 9];

- **Forced medical act or medical act performed without consent** – including forced contraception; forced sterilisation; forced abortion; any medical act/examination performed without explicit consent[10];
- **Non-medically necessary (harmful) procedures** – such as routine induction of labour; routine caesareans sections; routine episiotomies; non-evidence-based medicine practices, such as Hamilton manoeuvre[11] and fundal pressure[12][13];
- **Refusal or delay of care** – this includes delay or refusal to provide pain management medication during interventions[14]; delay or refusal to provide abortion care; withholding information and contact[15]; and refusal of a birth companion[16].

Box 1: Definitions of obstetric violence identified

The **World Health Organisation (WHO)** conceptualises obstetric violence (but without explicitly mentioning the term) as any abuse, disrespect, and mistreatment in childbirth caused by healthcare professionals that results in violations of women's dignity. This can consist of outright

6 Ibid

7 Mena-Tudela D., et al., Obstetric Violence in Spain (Part II): Interventionism and Medicalization during Birth.

8 Fundacja Rodzic po Ludzku, Report on monitoring maternity wards. Perinatal care in Poland in the light of women's experiences (*Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet*), 2018, https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

9 IPPF European Network. Gynaecological & Obstetric Violence, 2022, https://europe.ippf.org/sites/europe/files/2022-12/Gynaecological and Obstetric Violence - IPPF EN Research %26 Policy Paper.pdf

10 Ibid

11 The Hamilton manoeuvre is a way of inducing labour whereby the midwife or doctor peels off the lower pole of the amniotic sac using their fingers to release prostaglandins and trigger contractions.

12 This is also known as the Kristeller manoeuvre. This is where manual pressure is applied to the uppermost part of the uterus directed towards the birth canal to induce labour.

13 Mena-Tudela D., et al., Obstetric Violence in Spain (Part II): Interventionism and Medicalization during Birth.

14 RODA, Research results: Availability of women's health care during the COVID-19 pandemic 2021 (Rezultati istraživanja Dostupnost zdravstvene skrbi žena tijekom pandemije COVID-19, 2021), https://www.roda.hr/udruga/projekti/zagovaranje-za-zdravstvenu-skrb-zena-temeljenu-na-dokazima-u-doba-pandemije-covid-19/rezultati-istrazivanja-dostupnost-zdravstvene-skrbi-zena-tijekom-pandemije-covid-19.html

15 Association for the Prevention and Treatment of Violence in the Family (SPAVO). *Results from the Study on Obstetric violence in the Republic of Cyprus*, 2023, http://www.familyviolence.gov.cy/upload/20240115/1705314704-01871.pdf

16 RODA, Research results: Availability of women's health care during the COVID-19 pandemic 2021 (Rezultati istraživanja Dostupnost zdravstvene skrbi žena tijekom pandemije COVID-19, 2021), https://www.roda.hr/udruga/projekti/zagovaranje-za-zdravstvenu-skrb-zena-temeljenu-na-dokazima-u-doba-pandemije-covid-19/rezultati-istrazivanja-dostupnost-zdravstvene-skrbi-zena-tijekom-pandemije-covid-19.html

physical abuse, humiliation caused by verbal abuse, lack of confidentiality, and neglect that results in unnecessary pain and avoidable complications[17].

In **France**, the High Council for Equality between women and men (*Haut Conseil à l'Égalité entre les femmes et les hommes*, an independent governmental body) published a report in 2018 that defines obstetric and gynaecological violence as: the "*most serious sexist acts that can occur in the context of gynaecology and obstetrics follow-ups*", it specifies that: "*Sexist acts during gynaecological and obstetrical follow-up are gestures, comments, practices and behaviours carried out or omitted by one or more members of the nursing staff on a patient during gynaecological and obstetrical follow-up and which are part of the history of gynaecological and obstetric medicine, crossed by the desire to control women's bodies (sexuality and capacity to give birth). They are the work of caregivers - of all specialties - women and men, who do not necessarily intend to be abusive. They can take very diverse forms, from the most seemingly innocuous to the most serious*". On the basis of this definition, the HCE identifies six types of sexist acts ranging from a failure to take into account patients' discomfort to sexual violence[18].

The scientific council in **Luxembourg** issued recommendations on obstetric violence in 2021[19]. They do not provide a definition but draw upon the definition of violence against women as outlined in the Istanbul Convention and the definitions of obstetric and gynaecological violence by the High Council for Equality between Women and Men in France (see above) and the Institute of Research and Action for Women's Health.

In **Portugal**, a Resolution of the Parliament issued in 2021 defined the term 'obstetric violence' as any conduct directed at women, during labour, birth or the postpartum period, carried out without their consent, which, constituting an act of physical or psychological violence, causes pain, damage or unnecessary suffering or limits their power of choice and decision'[20].

2.1.1. A violence that occurs at the intersection of two structural issues

Obstetric and gynaecological violence is situated at the convergence of two structural crises: discrimination based on gender and the under-resourcing of healthcare systems and institutions.

a. The medicalisation of women's bodies as an historical product of modern medicine

In the medical realm, discrimination based on gender has its roots in two intertwined historical trends: the pathologisation of women's bodies and their increased biomedicalisation[21]. The first law on the

17 World Health Organisation. Statement on the Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth, World Health Organization; Geneva, Switzerland: 2015.

18 HCE, *Rapport du gouvernement français sur les actes sexistes durant le suivi obstétricale et gynécologique*, 2018, https://haut-conseil-egalite.gouv.fr/sante-droits-sexuels-et-reproductifs/actualites/article/actes-sexistes-durant-le-suivi-gynecologique-et-obstetrical-reconnaitre-et

19 Conseil Scientifique – Domaine de la Santé, *Les violences gynécologiques et obstétricales*, 2021. Available at : https://conseil-scientifique.public.lu/dam-assets/publications/sant%C3%A9-de-la-femme/violences-gynecologiques-et-obstetricales-valide.pdf

20 Assembly Resolution n. 181/2021, of 28 June (*Resolução da Assembleia da República n. 181/2021, de 28 de junho*), https://diariodarepublica.pt/dr/detalhe/resolucao-assembleia-republica/181-2021-165865615

21 Topçu, S. & Brown, P. The Impact of Technology on Pregnancy and Childbirth: Creating and Managing Obstetrical Risk in Different Cultural and Socio-Economic Contexts., Health, Risk & Society, 2022, 21(3-4):89-99, DOI: 10.1080/13698575.2019.1649922

subject of obstetric and gynaecological violence adopted in Venezuela in 2007 captures the significance of these trends, legislating that *'the appropriation of women's bodies and reproductive processes by health professionals through dehumanising treatments, abuses in medicalisation, or the pathologising of natural processes, lead[s] to loss of autonomy and decision-making capacity over their bodies and sexuality, [and] negatively affects women's quality of life'*[22]. The example of Venezuela was followed by several other Latin American countries who used similar definitions of this violence, such as the 2009 Argentinian law stating that '*obstetric violence is violence perpetrated on women's bodies and reproductive processes by health professionals. This is reflected through dehumanising treatments, abuses in medicalisation, and pathologising of natural processes*'[23].

The pathologisation of women's bodies and the increased biomedicalisation of reproduction are rooted in a patriarchal model that has shaped the medical realm. The work of Marilene Vuille notes that the historical positioning of gynaecology as a diagnostic and therapeutic know-how on the pathologies of women's genitals and as a discourse on 'women's nature' is symptomatic of patriarchal understandings of gender[24]. Indeed, the rise of hegemonic medical discourse on women's bodies as inherently defective and in need of biomedical intervention partly explains why women have historically been placed under the authority of healthcare professionals and have had their autonomy limited on matters related to their own reproductive and sexual health[25]. Institutionalised power imbalances between women and healthcare professionals have put women at risk of facing abusive behaviours and harmful practices[26], especially at times when they are more vulnerable (such as during childbirth or on the gynaecological table)[27]. Nowadays, through a set of normalised practices, healthcare professionals often perpetuate this institutionalised control over women's bodies; in this sense, they play (often unintentionally) a fundamental role in the reproduction of societal norms, which foster gender inequalities[28]. Therefore, obstetric and gynaecological violence can be considered as a form of institutionalised and gender-based violence which manifestations are deeply rooted in a long-lasting tradition of institutional, societal, and medical control over women's bodies.

b. Structural issues of the healthcare system, a breeding ground for violence

It is important to note that this violence does not occur only at the level of the interaction between the woman and her healthcare provider, and that a complex range of systemic and structural issues at the

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22 Organic Law of 23 April 2007, on the right of women to a life free of violence (*República Bolivariana de Venezuela. Ley Orgánica sobre el derecho de las mujeres a una vida libre de violencia*), Gaceta oficial de la República Bolivariana de Venezuela, n. 38.668, 2007, https://www.acnur.org/fileadmin/Documentos/BDL/2008/6604.pdf

23 Law 26.485 on comprehensive protection to prevent, punish and eradicate violence against women in the spheres in which they develop their interpersonal relationships (*República de Argentina 2009 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*), Boletín Oficial de la República de Argentina, año 17, No. 31.632.

24 Vuille M., Médecine, femmes et politique: histoire de doctrines et de pratiques transnationales (XXe siècle), 2017, doi: 10.13097/archive-ouverte/unige:97656

25 Molinier P, Rozée V, Schantz C, *Les violences obstétricales, un nouvel axe de recherche pour les études de genre, un nouveau défi pour le soin et la société*, in Cahiers du Genre, Association Féminin Masculin Recherches, 2021, https://www.cairn.info/revue-cahiers-du-genre-2021-2.html

26 Paris M., *Nous qui versons la vie goutte à goutte: féminismes, économie reproductive et pouvoir colonial à La Réunion*, 2020, Paris, Dalloz.

27 Akrich M., *La péridurale, un choix douloureux*, Cahiers du Genre, 1999, 25 : 17-48.

28 Castrillo B., *Dime quién lo define y te diré si es violento. Reflexiones sobre la violencia obstétrica*, Sexualidad, Salud y Sociedad (Rio de Janeiro), 2016, 24: 43-68.

level of the healthcare system and/or infrastructures contribute to exacerbating this violence. Those include poor supervisory structures and insufficient staffing, inadequate supply chains, poor policies and physical conditions of the healthcare infrastructures, and power dynamics that systemically disempower women[29]. For instance, staffing shortages, poor infrastructure, or lack of medications can create stressful working environments for healthcare providers, which may predispose them to behave abusively towards women, without necessarily being aware of it. As another example, the current shortage of well-trained physicians and midwives, coupled with their lack of experience and lack of knowledge of evidence-based medicine and guidelines—all a product of structural issues of our European healthcare systems—can increase the risk of instances of neglect and incidents considered as violent, yet oftentimes unintentional. Violent practices may coexist with other compassionate and respectful care practices, making them even more difficult to discern.

A number of studies have demonstrated the physical and psychological distress experienced by perinatal caregivers across Europe as a result of inadequate training, underfunding and a lack of resources. For example, research carried out in **Ireland** showed that rates of burnout are high among midwives compared to other professionals due to consistent staff shortages[30]. Similarly, approximately 20% of Norwegian midwives reported personal or work-related burnout[31]. Two studies in **France** also shed light on the severity of this issue: while one revealed that French maternity wards are facing issues with recruitment due to heavy workloads and constant stressful situations[32], the second highlighted that neonatologists work excessively and receive insufficient remuneration, which severely impacts on their mental health[33]. The crisis of underfunding within the healthcare system shows that obstetric and gynaecological violence is not always intentional, but is instead embedded in the structure of the medical system[34].

2.1.2. Consequences of obstetric and gynaecological violence

The consequences of obstetric and gynaecological violence can severely impact on women's physical and mental health. Venezuelan law specifies that obstetric violence leads to a loss of women's autonomy and a loss of ability to freely decide about their body and their sexuality, which has a negative impact on their quality of life[35]. Violence can lead to feelings of guilt, a lack of self-esteem and

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29 Bohren M. A., J. P. Vogel, E. C. Hunter, O. Lutsiv, S. K. Makh, J. P. Souza, C. Aguiar, F. Saraiva Coneglian, A. L. A. Diniz, Ö. Tunçalp, D. Javadi, O. T. Oladapo, R. Khosla, M. J. Hindin and A. M. Gülmezoglu. *The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review*, PLOS Medicine, 2015, 12(6): e1001847.

30 Doherty J., O'Brien D., *Reducing Midwife Burnout at Organisational Level — Midwives Need Time, Space and a Positive Work-Place Culture,* Women and Birth, 2022, 35 (6): e563-72. https://doi.org/10.1016/j.wombi.2022.02.003

31 Henriksen L., Lukasse M., *Burnout Among Norwegian Midwives and the Contribution of Personal and Work-Related Factors: A Cross-Sectional Study,* Sexual & Reproductive Healthcare, 2016, 9: 42-47. https://doi.org/10.1016/j.srhc.2016.08.001.

32 Merlier M., Ghesquière L., Huissoud C, Drumez E., Morel O., Garabedian C., *How do French Obstetrician-Gynaecologists Perceive Their Quality of Life? A National Survey,* European Journal of Obstetrics & Gynecology and Reproductive Biology, 2023, 286: 112-17. https://doi.org/10.1016/j.ejogrb.2023.05.010.

33 Zana-Taïeb E., Kermorvant E., Beuchée A., Patkaï J., Rozé J. C., Torchin H. and on the behalf of the French Society of Neonatology, *Excessive Workload and Insufficient Night-Shift Remuneration Are Key Elements of Dissatisfaction at Work for French Neonatologists,* Acta Paediatrica, 2023, 112 (10): 2075-83. https://doi.org/10.1111/apa.16871

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

35 Organic Law of 23 April 2007, on the right of women to a life free of violence (*República Bolivariana de Venezuela. Ley Orgánica sobre el derecho de las mujeres a una vida libre de violencia*), Gaceta oficial de la República Bolivariana de Venezuela, n. 38.668, 2007, https://www.acnur.org/fileadmin/Documentos/BDL/2008/6604.pdf

even to severe psychological disorders such as post-partum acute stress disorder (ASD), post-traumatic stress disorder (PTSD) and post-partum depression (PPD)[36].

A study conducted in **France** shows that women who declared having suffered inappropriate behaviour from caregivers during pregnancy or childbirth are more likely to develop post-traumatic stress two months after their delivery[37]. In addition, the Doxa survey conducted in **Italy** showed that 11% of mothers admit to having suffered trauma due to care in hospital and consequently preferred to postpone the choice of having another pregnancy for many years, with significant consequences on fertility at a national level. For 6% of the total, the trauma was so severe that they decided not to have any more children, with an estimated 20,000 unborn children per year[38]. Similarly, according to data for 2021, the incidence rate of post-traumatic stress disorders in the perinatal period in **Catalonia (Spain)** affected approximately 2 out of 10 women. However, the data reveal a clear correlation between income and PTSD. Women on lower incomes experienced post-traumatic stress at a higher rate per 1,000 people, registering at a rate of 23.5 compared to 17.7 among middle-income women while among high-income women, the incidence is practically non-existent[39]. The stories of women collected during the Me Too during Childbirth social media campaign further corroborate evidence that abuse, violence and neglect experienced during childbirth in **Finnish** hospitals left women severely traumatised and suffering from post-traumatic stress symptoms in the months and years following the birth[40].

'*Errance medicale*', or 'medical wandering' has been coined to explain how this violence can also have an impact on future gynaecological, obstetrical and more general medical follow-ups, leading some women to forgo medical care[41]. Severe abuse can also impact women's physical and socioeconomic health, and the health consequences of obstetric and gynaecological violence can be long-lasting, chronic and fatal. For example, in a study carried out in India, women who experienced obstetric violence reported many self-health, economic, family and social consequences, such as injury, infection, stress, deterioration in spousal relationship and discrimination among others[42]. Finally, they can have an impact on the professional, family, friendly and intimate lives of women, with in certain

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36 Goaz Melet S., Feldman N., & Padoa A., Obstetric Violence – Since when and Where to: Implications and Preventive Strategies, Harefuah, 2022, 161(9): 556–561.

37 Leavy E., Cortet M., Huissoud C., Desplanches T., Sormani J., Viaux-Savelon S., Dupont C., Pichon S., Gaucher L., *Disrespect during Childbirth and Postpartum Mental Health: A French Cohort Study*, BMC Pregnancy and Childbirth, 2023, 23(1): 241. https://doi.org/10.1186/s12884-023-05551-3

38 OVOItalia. Doxa-OVOItalia Survey, 2017, Doxa-OVOItalia Survey | Observatory on Obstetric Violence Italy (OVOItalia) (wordpress.com)

39 Escuriet P. R., Trespalacios E. X., Morros Serra, M., Alcaraz Vidal, L., Brigidi, S., Bueno Lopez, V., et al. *Pla per a l'abordatge de la violència obstètrica i la vulneració dels drets sexuals i reproductius (2023–2028)*. Barcelona: Generalitat de Catalunya; 2023.

40 United Nations. *Report on the Mistreatment and violence against women during reproductive health care and childbirth in Finland*, 2019, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf

41 Évrard A., Reconnaître et analyser les violences obstétricales, une démarche pertinente d'évaluation et d'amélioration des pratiques, Périnatalité. 2020;12(4):172-7.

42 Acharya A. K., Sarangi R., Behera S. S., *Experiences and Impacts of Obstetric Violence on Indian Women Within the Public Healthcare System*. Journal of Feminist, Gender and Women Studies, 2021, (11), 37-45.

cases an alteration of the couple's relationship, sexual life and a deterioration of the relationship with the child[43], therefore impacting on women's sexual and reproductive rights.

2.2. International and European legal and policy framework recognising obstetric and gynaecological violence

First legally conceptualised as a form of gender-based violence in some countries of Latin America[44], obstetric and gynaecological violence has only recently been placed at the forefront of the political agenda in Europe. Debates around acknowledging the issue and its widespread nature have emerged over the past ten years in several Member States, resulting in the adoption of specific recommendations against this type of violence by political institutions in Europe.

2.2.1. International framework

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[45], particularly Article 12, requires governments to take all appropriate measures to eliminate discrimination against women in the field of health care, including access to family planning services and in all matters relating to pregnancy, childbirth and the postpartum period[46]. In connection with this article, General Recommendations 24 and 31 on women and health state that health services should ensure women's prior informed consent, respect their dignity, ensure their privacy and take into account their needs, perspectives and autonomy.

In 2014, the World Health Organisation (WHO) declared that all women have the right to the highest standard of health care and made a series of recommendations to ensure the right to dignified and respectful care during pregnancy, childbirth and the postpartum period, and to prevent violence or discrimination in this area. At the same time, target 2.1 of the WHO Action Plan on Sexual and Reproductive Health[47] focuses on addressing sexual and reproductive health needs and concerns. Key

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43 Haut Conseil à l'égalité (HCE). Les actes sexistes durant le suivi gynécologique et obstétrical: Des remarques aux violences, la nécessité de reconnaître, prévenir et condamner le sexisme. Paris: HCE; 2018. p. 164. Rapport n° 2018-06-26-SAN-034.

44 Venezuela, Argentina, Chile, Bolivia, Mexico and Uruguay, https://cordis.europa.eu/project/id/700946

45 UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf

46 It is interesting to note that this provision is reiterated in article 14(b) but with a focus on rural women. This shows that there was already a recognition of marginalised women receiving differential treatment (see D. Kaother Jeanrenaud, Obstetric violence in international human rights law, October 26, 2022, Human Rights Pulse, https://www.humanrightspulse.com/mastercontentblog/obstetric-violence-in-international-human-rights-law

47 World Health Organisation, Action Plan for Sexual and Reproductive Health: Towards Achieving the 2030 Agenda for Sustainable Development in Europe – Leaving No One Behind', 2016, https://iris.who.int/bitstream/handle/10665/338130/66wd13e-SexualReproHealth-160524.pdf?sequence=1. 'Objective 2.1: Attend to all people's needs or concerns in relation to sexuality and sexual and reproductive health and rights. Key actions would include: (a) facilitating access to age-appropriate, comprehensive and scientifically accurate information and education about relationships and sexual and reproductive health and rights; (b) ensuring that such information and education recognizes and addresses the various needs and concerns of people based on biological and gender differences; (c) ensuring that health care personnel are educated and trained to provide appropriate services related to sexuality and sexual and reproductive health and rights, and that the exercise of conscientious objection does not jeopardize people's access to such services; (d) organizing dedicated services for those who may have difficulty accessing sexual and reproductive health services, including adolescents, people who are unmarried, people with socioeconomic disadvantage, those living in institutions, migrants and asylum seekers, people living with HIV, people

actions include improving access to sexual and reproductive health information and education, training of health workers, and accessibility and adaptability of health services.

More recently, the United Nations General Assembly adopted Resolution 71/170 (2026) based on the report of the Special Rapporteur on violence against women in reproductive health services, where Dubravka Simonovic pays special attention to the obstetric part and violence from a human rights perspective[48]. Finally, the thematic report by UN Special Rapporteur Tlaleng Mofoken, 'Sexual and reproductive health rights: Challenges and opportunities during the COVID-19 pandemic' (2021) explicitly links the pandemic to an increase in manifestations of gender-based violence in health facilities. However, it is important to note that these resolutions and recommendations are not enforceable (as in not adhering to them does not lead to any penalties) even though the United Nations report reminds that the State is responsible for violence and human rights violations.

2.2.2. European framework

Resolution No. 2306 of the Parliamentary Assembly of the **Council of Europe** on Obstetrical and Gynaecological Violence adopted in 2019 frames obstetric violence as a form of gender-based violence, '*a form of violence that has long been hidden and is still too often ignored*'; and adds: '*This violence reflects a patriarchal culture that is still dominant in society, including in the medical field*'[49]. In the conclusion, it highlights that gynaecological and obstetric violence reveals profound gender inequalities, whereby women's words are not listened to or considered. In recognition that this violence reveals a desire for control over women's bodies, it advocates efforts to promote gender equality in all areas to put an end to such practices.

In addition, in 2021, the **European Parliament** adopted the Resolution on sexual and reproductive health and rights in the EU in the context of women's health. Among the forms of sexual and reproductive health abuse, discrimination and motivations by gender hatred, gynaecological and obstetric violence were highlighted[50].

with disabilities, lesbian, gay, bisexual, transsexual and intersex people, drug users and people engaged in sex work; (e) ensuring the provision of necessary counselling and evidence-based treatment for women and men suffering from hormone deficiency, including menopause; (f) arranging access to professional counselling and treatment for people with sexual dysfunction; and (g) providing older people with information and services related to sexuality and sexual health.' (p.12).

48 United Nations, A human rights-based approach to mistreatment and violence against women in reproductive health services with particular reference to childbirth and obstetric violence, 2019, https://digitallibrary.un.org/record/3823698?v=pdf#files.

49 Council of Europe Parliamentary Assembly, Resolution 2306: Obstetric and Gynaecological Violence, 2019, https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28236

50 European Parliament resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health (2020/2215(INI)), https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52021IP0314

3. MEASURING OBSTETRIC AND GYNAECOLOGICAL VIOLENCE IN THE EUROPEAN UNION

Key findings

Several prevalence studies have been carried out throughout the EU Member States, providing valuable information on the widespread nature of obstetric and gynaecological violence.

However, in the absence of common definitions and standardised data collection processes, there is a lack of comparative data on obstetric and gynaecological violence across the European Union.

Specific groups of women appear most at risk of facing obstetric and gynaecological violence in the EU 27 Member States, due to a combination of factors and identity characteristics (such as social status, sexual orientation, age, or deviation from the dominant gender norms).

The organisational structures of healthcare systems can impact on the prevalence of some forms of obstetric and gynaecological violence.

The sudden reorganisation of care and related restrictions that were brought by the COVID-19 pandemic (such as the imposition of masks, the absence of birth/consultation companion, etc.) exacerbated obstetric and gynaecological violence, limiting women's autonomy further and increasing their vulnerability. The pandemic thus had a considerable influence in revealing the prevalence and severity of obstetric and gynaecological violence, and has contributed to putting the issue on the agenda.

3.1. Prevalence[51] of obstetric and gynaecological violence across the 27 EU Member States

Overall, there are limited studies that assess the prevalence of obstetric and gynaecological violence across the EU.

3.1.1. Data collected reveals widespread forms of violence

While some data have been collected through academic studies, government-funded studies and research led by civil society organisations in several Member States (BE, BG, CZ, DK, DE, EE, IE, EL, ES, FI, FR, HR, IT, CY, LV, LT, LU, HU, NL, PL, PT, RO, SI, SK, SE), very few studies use the term 'violence' to describe these practices. Instead, these studies focus on collecting data on women's experiences in the health system (including women's experiences of having their rights violated) and statistical data on the types of procedures used during labour to assess the extent of the medicalisation of childbirth.

These studies have several limitations, including small sample sizes that may not be necessarily representative of the general population. The majority of studies focus on obstetric violence while there are very few studies on the prevalence of gynaecological violence. In addition, different definitions of what constitutes different forms of obstetric and gynaecological violence across Member States present difficulties for comparison. Nevertheless, these studies provide clear information on the widespread nature of obstetric and gynaecological violence and give insight into its different forms.

Though not always adopting the term 'violence', forms of obstetric and gynaecological violence studied include any medical act/examination performed without explicit consent; non-evidence based practices such as the Hamilton manoeuvre and fundal pressure (and husband's stitch); non-medically necessary procedures, i.e., high rates of c-sections that exceed WHO recommendations; physical abuse such as painful vaginal examination, inappropriate sexual conduct and aggressive physical contact;

[51] In this study, we adopt the term 'prevalence' to understand the scope, trends and extent of obstetric and gynaecological violence across EU Member States in which studies have been carried out

verbal abuse; neglect, including not being treated with respect of dignity; withholding information and contact; no birth companion allowed; discrimination; refusal of care, including insufficient pain relief, lack of privacy; and physical force or coercion, such as restricted movement or no choice of birth position. Since most studies focus only on obstetric violence, the table below presents the prevalence rates of the different forms of obstetric violence as reported in some of the studies identified across the Member States.

Table 1: Prevalence of different forms of obstetric violence across Member States

Form of obstetric violence	Prevalence
Lack of consent	BE: Consent was absent in 49% of medical procedures during obstetric care[52]. CZ: 100% of women reported being very or rather bothered by the fact that the abilities and competencies of the mother are belittled in maternity hospitals and that interventions are carried out without her consent[53]. DE: 42.8% reported non-consented interventions[54]. EL: 40% of women had an episiotomy, only half of whom gave their consent[55]. ES: In two different studies carried out in 2019 and 2021, 45.8% reported lack of informed consent[56] and 37% were not requested to provide informed consent of an unnecessary and/or painful procedure[57], respectively. FI: 30% of interventions were performed without consent or in secret[58].

[52] Sample of 4,226 women, 2021, in Guiot F., *Plateforme citoyenne pour une naissance respectée*, https://nomadit.co.uk/conference/easa2024/paper/79852

[53] Sample of 647 women, 2021, in Durnova A., Hejzlarova E., *Role Intimity v české kontroverzi ohledně domácích porodů*, https://iss.fsv.cuni.cz/veda-vyzkum/granty/aktualne-resene-projekty/domaci-porody-v-cesku

[54] Sample of 2,045 women, 2023, in Limmer C. M., Stoll K., Vedam S., Leinweber J., Gross M. M., Measuring disrespect and abuse during childbirth in a high-resource country: Development and validation of a German self-report tool, 2023 Nov:126:103809.doi: 10.1016/j.midw.2023.103809. Epub 2023 Sep 2, https://pubmed.ncbi.nlm.nih.gov/37689053/

[55] Sample of 3,075 women, 2017, in *Έρευνα για την περιγεννητική φροντίδα και τον τοκετό στην Ελλάδα (1990-2017)*, http://www.encahellas.eu/ereuna2018.html

[56] Sample of 17,677 women, 2019, in *¿Violencia obstétrica en España, realidad o mito? 17.000 mujeres opinan*, Musas, vol. 4, núm. 1(2019): 77-97. ISSN 2385-7005. DOI: 10.1344/musas2019.vol4.num1.5, https://revistes.ub.edu/index.php/MUSAS/article/view/vol4.num1.5/28621

[57] Sample of 17,541 women, 2021, in Mena-Tudela D., Iglesias-Casás S., González-Chordá V. M., Cervera-Gasch A., Andreu-Pejó L., Valero-Chilleron M. J., *Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences*, https://www.mdpi.com/1660-4601/17/21/7726

[58] Sample of 60, 2019, in Report on the Mistreatment and violence against women in reproductive health care and childbirth in Finland, A response to the call for submissions by the OHCHR-UN,

Form of obstetric violence	Prevalence
	FR: 20% of women reported that that their agreement was not requested for the administration of oxytocin during labour and 51.8% for performing an episiotomy[59]. HU: 7 out of 10 women experienced episiotomy and half of them did not give consent[60]. HU: 10.2% of women did not give consent to a c-section; 25.4% of women who were induced did not give their consent[61]. IT: 30% of women in the last 14 years, i.e. 1.6 million women (61% of those who have undergone an episiotomy) declare that they have not given informed consent to authorise the intervention. For 15% of the women who experienced this practice, equal to about 400,000 mothers, their genital organs were impaired[62]. IT: 1 in 3 women felt in some way cut off from the fundamental decisions and choices that concerned their childbirth[63]. NL: Of those who received an episiotomy, 41.7% were not asked for their consent, and of those who were administered postpartum oxytocin, 47.5% were not asked for their consent[64]. PL: 26% experienced a situation in the emergency room in which an examination was performed without consent, insensitively or in a painful way[65].

https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf

59 Sample of 12,723 women, 2022, in Le Ray C., Lelong N., Cinelli H., Blondel B., *Results of the 2021 French National Perinatal Survey and trends in perinatal health in metropolitan France since 1995,* Science Direct, https://www.sciencedirect.com/science/article/pii/S246878472200191X

60 Sample of 537 women, in Vaczi I., *Ethical Implications of Obstetric Care in Hungary: Results from the Mother-Centred, Pregnancy Care Survey,* https://semmelweis.hu/ejmh/2018/06/10/ethical-implications/

61 Sample of 1,257 women, 2018, in Szebik I., Susanszky E., Szanto Z., Susanszky A., Rubashkin N., *Ethical implications of obstetric care in Hungary: Results from the Mother-Centred Pregnancy Care Survey,* European Journal of Mental Health 13 (2018) 51–69, https://real.mtak.hu/81412/1/ejmh_2018_1_szebik_et_al_51_69.pdf

62 Sample of 5 million women, 2017, in *Doxa-OVOItalia Surve, Observatory on Obstetric Violence Italy (OVOItalia),* https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/

63 Sample of 5 million women, 2017, ibid

64 Sample of 13,359 people, 2023, in van der Pijl M. S. G., Klein Essink M., van der Linden T., Verweij R., Kingma, Hollander M. H., de Jonge A., Verhoeven C. J., *Consent and refusal of procedures during labour and birth: a survey among 11 418 women in the Netherlands,* BMJ Journals. https://qualitysafety.bmj.com/content/early/2023/05/18/bmjqs-2022-015538

65 Sample of 8,378 women, 2018, in *Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet,* https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

Form of obstetric violence	Prevalence
	PL: 14.1% were given an episiotomy without their consent[66]. PT: 62.2% of women did not have their consent requested for the use of instruments[67]. SE: 36% of women did not have their consent requested for instrumental vaginal birth[68]. SK: 55.1% signed informed consent upon admission to the maternity ward, they received informed consent only in written form and were not further informed about its content[69]. SK: 48% of women had an episiotomy; 67% were not asked for their consent for the procedure[70].
Unnecessary or painful procedures or non-evidence-based practices	BE: 6.3% underwent the 'husband's stitch'[71]. ES: In two different studies carried out in 2019 and 2021, 38% underwent unnecessary or potentially dangerous procedures during labour[72] and 44% of women underwent unnecessary and/or painful procedures[73], respectively. ES: 21.5% of women underwent the Hamilton manoeuvre[74].

66 Sample of 10,257 women, 2021, in *Raport „Opieka okołoporodowa podczas pandemii COVID-19 w świetle doświadczeń kobiet i personelu medycznego*, https://rodzicpoludzku.pl/raporty/raport-opieka-okoloporodowa-podczas-pandemii-covid-19-w-swietle-doswiadczen-kobiet-i-personelu-medycznego/

67 Sample of 1,845 women, 2022, in Costa R., Barata C., Dias H., Rodrigues C., Santos T., Mariani I., Covi B., Pessa Valente E., Lazzerini M., IMAgiNE EURO study group, *Regional differences in the quality of maternal and neonatal care during the COVID-19 pandemic in Portugal: Results from the IMAgiNE EURO study*, 18 December 2022, International Journal of Gynaecology &Obstetrics https://obgyn.onlinelibrary.wiley.com/doi/10.1002/ijgo.14507

68 Sample of 4,528 women, 2022, in Zaigham M., Linden K., Sengpiel V., Mariani I., Pessa Valente E., Covi B., Lazzerini M., Elden H., or the IMAgiNE EURO Study Group, *Large gaps in the quality of healthcare experienced by Swedish mothers during the COVID-19 pandemic: A cross-sectional study based on WHO standards*, Women and Birth Volume 35, Issue 6, November 2022, Pages 619-627, https://www.sciencedirect.com/science/article/pii/S1871519222000105?via%3Dihub

69 Sample of 3,146 women, 2021, in Patakyová M., Hovorme otvorene o pôrodoch: ľudskoprávny prístup pri poskytovaní zdravotnej starostlivosti pri pôrodoch, https://vop.gov.sk/wp-content/uploads/2021/09/Sprava_porody_FINAL.pdf

70 Sample of 3,164 women, 2021, ibid

71 Sample of 3,919 women, 2021, in Platforme citoyenne pour une naissance respectée, *Accoucher en Belgique francophone avant et pendant le covid*, https://www.naissancerespectee.be/wp-content/uploads/2022/02/PCNR-synthese-Rapport-2021.pdf

72 Sample of 17,677 women, 2019, in *¿Violencia obstétrica en España, realidad o mito? 17.000 mujeres opinan*, Musas, vol. 4, núm. 1(2019): 77-97. ISSN 2385-7005. DOI: 10.1344/musas2019.vol4.num1.5, https://revistes.ub.edu/index.php/MUSAS/article/view/vol4.num1.5/28621

73 Sample of 17,541 women, 2021, in Mena-Tudela D., Iglesias-Casás S., González-Chordá V. M., Cervera-Gasch A., Andreu-Pejó L., Valero-Chilleron M. J., *Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences*, https://www.mdpi.com/1660-4601/17/21/7726

74 Sample of 8,866 women, 2021, ibid

Form of obstetric violence	Prevalence
	FI: 38% underwent a violent or painful procedure[75]. PL: 57.6% of women reported that staff applied fundal pressure with their hand, 39% with their elbow, and 18.2% with their whole body[76].
Rates of c-sections (that exceed the WHO recommendations), indicating over-medicalisation[77]	AT: 30%[78] BG: 48.7% CY: 52.2% DE: 31.8% ES: 25.7%. HR: 26.2% HU: 41.5% IT: 32% of all women give birth by c-section. In 14% of cases, it was a caesarean section planned on the doctor's instructions, while only 3% of women explicitly requested it[79]. LU: 29.5% MT: 30.9% RO: 44% PL: 44.4% SK: 30.1%

75 Sample of 60, 2019, in Report on the Mistreatment and violence against women in reproductive health care and childbirth in Finland, A response to the call for submissions by the OHCHR-UN, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf
Sample of 8,378 women, 2018. In *Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet*, https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

77 The WHO recommends the c-section rate to be between 10-15%.

78 Amyx M., Philibert M.,Farr A., Donati S., Smárason A. K., Tica V., Velebil P., Alexander S., Durox M., Fernandez Elorriaga M., Heller G., Kyprianou T., Mierzejewska E., Verdenik I., Zīle-Velika I., Zeitlin J., for the Euro-Peristat Research Group, *Trends in caesarean section rates in Europe from 2015 to 2019 using Robson's Ten Group Classification System: A Euro-Peristat study*, 01 October 2023, https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.17670?af=R

79 Sample of 5 million women, 2017, in *Doxa-OVOItalia Survey, Observatory on Obstetric Violence Italy - OVOItalia)*, https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/

Form of obstetric violence	Prevalence
Rates of episiotomies and induced labours that exceed the WHO guidelines[80]	ES: rates of episiotomy have dropped from 42.1% in 2010 to 27.5% in 2018[81], however this is still considerably higher than the WHO recommendation. ES: 32.4% of births were induced, including an upward trend observed in the number of labours induced with the administration of oxytocin[82].
Verbal abuse during obstetric care	BE: 6% reported experiencing verbal violence[83]. DE: Two surveys revealed consistent results in that there were between 1 in 5 and 1 in 3 women who suffered from verbal abuse in obstetric care[84],[85]. EL: 16.5% reported experiencing verbal violence[86]. ES: 34.5% of women faced ironic or discrediting remarks and 31.4% were called nicknames or were infantilised[87]. ES: 25.1% of women reported facing verbal abuse during obstetric care[88].

[80] The WHO recommends episiotomy rates to be under 10% and for the induction of labour to be between 5% and 10%.

[81] Ministerio de Sanidad, Atención perinatal en España: Análisis de los recursos físicos, humanos, actividad y calidad de los servicios hospitalarios, 2010-2018 Madrid', 2021, https://www.sanidad.gob.es/estadEstudios/estadisticas/docs/Informe_Atencion_Perinatal_20 10-2018.pdf

[82] Ibid

[83] Sample of 4,226 women, 2021, in Platforme citoyenne pour une naissance respectée, *Accoucher en Belgique francophone avant et pendant le covid,* https://www.naissancerespectee.be/wp-content/uploads/2022/02/PCNR-synthese-Rapport-2021.pdf

[84] Sample of 2,045 women, 2023, in Limmer C. M., Stoll K., Vedam S., Leinweber J., Gross M. M., Measuring disrespect and abuse during childbirth in a high-resource country: Development and validation of a German self-report tool, 2023 Nov:126:103809.doi: 10.1016/j.midw.2023.103809. Epub 2023 Sep 2, https://pubmed.ncbi.nlm.nih.gov/37689053/

[85] Sample of 1,079, 2023, in Beck-Hiestermann F. M. L., Gries S., Mehl S., Gumz A., *Adverse Childbirth Experiences - Results of an Online Survey of Woman During Their First Year Postpartum,* October 2023, DOI:10.21203/rs.3.rs-3408649/v1, https://www.researchgate.net/publication/374471617_Adverse_Childbirth_Experiences_-_Results_of_an_Online_Survey_of_Woman_During_Their_First_Year_Postpartum

[86] Sample of 553 women, 2021, in *The experience of childbirth in public hospitals. An investigation of the phenomenon of obstetric violence in Greece. (Αγγλική),* Η εμπειρία του τοκετού στα δημόσια νοσοκομεία. Διερεύνηση του φαινομένου της άσκησης μαιευτικής βίας στην Ελλάδα, https://apothesis.eap.gr/archive/item/92128

[87] Sample of 17,541 women, 2021, in Mena-Tudela D., Iglesias-Casás S., González-Chordá V. M., Cervera-Gasch A., Andreu-Pejó L., Valero-Chilleron M. J., *Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences,* https://www.mdpi.com/1660-4601/17/21/7726

[88] Sample of 899 women, 2021, in Martínez-Galiano J. M., Martinez-Vazquez S., Rodríguez-Almagro J., Hernández-Martinez A., *The magnitude of the problem of obstetric violence and its associated factors: A cross-sectional study,* ScienceDirect, https://www.sciencedirect.com/science/article/pii/S1871519220303590?via%3Dihub

Form of obstetric violence	Prevalence
	FR: 10% of women reported having been exposed to inappropriate words or attitudes on the part of caregivers 'sometimes or often' during their pregnancy, childbirth or stay in the maternity ward[89]. PL: 24% of respondents indicated that staff made inappropriate comments; 20% felt that they were looked down upon; 17.1% were disrespected; 15.6% suffered from staff raising their voice; 11.8% faced criticism; and 10.1% faced ridicule[90] in 2018. PL: 21% of women experienced verbal abuse[91] in 2021. PT: 23.3% of women were victims of verbal abuse[92].
Physical violence, such as painful vaginal examination, inappropriate sexual conduct and aggressive physical contact	BE: 3% reported experiencing physical violence[93]. 95% of women who suffered these acts were not aware that they were considered violence. DE: Two surveys revealed similar results, with one finding that 30.9% reported experiencing physical violence during childbirth[94] and the other that 33.6% experienced physical violence in obstetric care[95].

89 Sample of 12,723 women, 2022, in Le Ray C., Lelong N., Cinelli H., Blondel B., *Results of the 2021 French National Perinatal Survey and trends in perinatal health in metropolitan France since 1995,* Science Direct, https://www.sciencedirect.com/science/article/pii/S246878472200191X

90 Sample of 8,378 women, 2018, in. *Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet*, https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

91 Sample of 10,257 women, 2021, in *Raport „Opieka okołoporodowa podczas pandemii COVID-19 w świetle doświadczeń kobiet i personelu medycznego*, https://rodzicpoludzku.pl/raporty/raport-opieka-okoloporodowa-podczas-pandemii-covid-19-w-swietle-doswiadczen-kobiet-i-personelu-medycznego/

92 Sample of 1,845 women, 2022, in Costa R., Barata C., Dias H., Rodrigues C., Santos T., Mariani I., Covi B., Pessa Valente E., Lazzerini M., IMAgiNE EURO study group, *Regional differences in the quality of maternal and neonatal care during the COVID-19 pandemic in Portugal: Results from the IMAgiNE EURO study,* 18 December 2022, International Journal of Gynaecology &Obstetrics https://obgyn.onlinelibrary.wiley.com/doi/10.1002/ijgo.14507

93 Sample of 4,226 women, 2021, in Platforme citoyenne pour une naissance respectée, *Accoucher en Belgique francophone avant et pendant le covid*, https://www.naissancerespectee.be/wp-content/uploads/2022/02/PCNR-synthese-Rapport-2021.pdf

94 Sample of 1,079, 2023, in Beck-Hiestermann F. M. L., Gries S., Mehl S., Gumz A., *Adverse Childbirth Experiences - Results of an Online Survey of Woman During Their First Year Postpartum,* October 2023, DOI:10.21203/rs.3.rs-3408649/v1, https://www.researchgate.net/publication/374471617_Adverse_Childbirth_Experiences_-_Results_of_an_Online_Survey_of_Woman_During_Their_First_Year_Postpartum

95 Sample of 2,045 women, 2023, in Limmer C. M., Stoll K., Vedam S., Leinweber J., Gross M. M., Measuring disrespect and abuse during childbirth in a high-resource country: Development and validation of a German self-report tool, 2023 Nov:126:103809.doi: 10.1016/j.midw.2023.103809. Epub 2023 Sep 2, https://pubmed.ncbi.nlm.nih.gov/37689053/

Form of obstetric violence	Prevalence
	ES: 54.5% of women reported experiencing physical violence during obstetric care[96]. EL: 15.2% reported experiencing physical obstetric violence[97]. FI: 5% experienced physical coercion or rough-handed touch without consent[98]. IT: 21% reported being victims of some form (physical or psychological) of obstetric violence in their first experience of motherhood[99].
Neglect (including not treated with dignity)	DE: Two surveys reported consistent findings, with one showing that 30% of women felt neglected or ignored by healthcare providers in obstetric care[100] while in the other, 30% reported experiencing neglect in childbirth[101]. IT: 40% of mothers stated that they experienced actions violating their personal dignity[102]. LV: 17.4% of women reported suffering from abuse in childbirth[103]. NL: 54% experienced at least one form of disrespect and abuse, consisting of 39.8% were given a lack of choices, 29.9% did not

[96] Sample of 899 women, 2021, in Martínez-Galiano J. M., Martinez-Vazquez S., Rodríguez-Almagro J., Hernández-Martinez A., *The magnitude of the problem of obstetric violence and its associated factors: A cross-sectional study*, ScienceDirect, https://www.sciencedirect.com/science/article/pii/S1871519220303590?via%3Dihub

[97] Sample of 1,079, 2023. DOI: 10.21203/rs.3.rs-3408649/v1

[98] Sample of 60, 2019, in *Report on the Mistreatment and violence against women in reproductive health care and childbirth in Finland, A response to the call for submissions by the OHCHR-UN,* https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf

[99] Sample of 5 million, 2017, in *Doxa-OVOItalia Survey, Observatory on Obstetric Violence Italy - OVOItalia),* https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/

[100] Sample of 2,045 women, 2023, in Limmer C. M., Stoll K., Vedam S., Leinweber J., Gross M. M., Measuring disrespect and abuse during childbirth in a high-resource country: Development and validation of a German self-report tool, 2023 Nov:126:103809.doi: 10.1016/j.midw.2023.103809. Epub 2023 Sep 2, https://pubmed.ncbi.nlm.nih.gov/37689053/

[101] Sample of 1,079, 2023, in Beck-Hiestermann F. M. L., Gries S., Mehl S., Gumz A., *Adverse Childbirth Experiences - Results of an Online Survey of Woman During Their First Year Postpartum,* October 2023, DOI:10.21203/rs.3.rs-3408649/v1, https://www.researchgate.net/publication/374471617_Adverse_Childbirth_Experiences_-_Results_of_an_Online_Survey_of_Woman_During_Their_First_Year_Postpartum

[102] Sample of 5 million, 2017, in *Doxa-OVOItalia Survey, Observatory on Obstetric Violence Italy - OVOItalia),* https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/

[103] Sample of 2,079 women, 2022, in Amyx M., Philibert M.,Farr A., Donati S., Smárason A. K., Tica V., Velebil P., Alexander S., Durox M., Fernandez Elorriaga M., Heller G., Kyprianou T., Mierzejewska E., Verdenik I., Zīle-Velika I., Zeitlin J., for the Euro-Peristat Research Group, *Trends in caesarean section rates in Europe from 2015 to 2019 using Robson's Ten Group Classification System: A Euro-Peristat study*, 01 October 2023, https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.17670?af=R

Form of obstetric violence	Prevalence
	receive enough communication, 21.3% perceived a lack of support and 21.1% received harsh or rough treatment/physical violence[104] PT: 31.9% of women reported not being treated with dignity[105]. SE: 18.4% of women were not treated with dignity[106]. SI: 15.9% of women received disrespectful care during childbirth[107].
Withholding information and contact (refusal of care)	CY: 31% received inadequate information and support, inadequate medical documentation and uninformed consent procedures[108]. ES: 42.5% of women were not provided with enough information[109]. FI: 20% had information withheld from them or were lied to[110]. IT: 27% of mothers complained of a lack of support and information on breastfeeding initiation[111]. LV: 32.7% reported inadequate breastfeeding support[112].

[104] Sample of 12,239 women, 2022, in van der Pijl M. S. G., Verhoeven C. J. M., Verweij R., van der Linden T., Kingma E., Hollander M. H., de Jonge A., *Disrespect and abuse during labour and birth amongst 12,239 women in the Netherlands: a national survey*, Reproductive Health Journal, 8 July 2022, https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.17670?af=Rhttps://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-022-01460-4

[105] Sample of 1,845 women, 2022, in Costa R., Barata C., Dias H., Rodrigues C., Santos T., Mariani I., Covi B., Pessa Valente E., Lazzerini M., IMAgiNE EURO study group, *Regional differences in the quality of maternal and neonatal care during the COVID-19 pandemic in Portugal: Results from the IMAgiNE EURO study*, 18 December 2022, International Journal of Gynaecology &Obstetrics https://obgyn.onlinelibrary.wiley.com/doi/10.1002/ijgo.14507

[106] Sample of 4,528 women, 2022, in Zaigham M., Linden K., Sengpiel V., Mariani I., Pessa Valente E., Covi B., Lazzerini M., Elden H., or the IMAgiNE EURO Study Group, *Large gaps in the quality of healthcare experienced by Swedish mothers during the COVID-19 pandemic: A cross-sectional study based on WHO standards*, Women and Birth Volume 35, Issue 6, November 2022, Pages 619-627, https://www.sciencedirect.com/science/article/pii/S1871519222000105?via%3Dihub

[107] Sample of 504 women, 2018. https://dk.um.si/Dokument.php?id=140854&lang=slv

[108] Sample of 634 women, 2023, in *Αποτελέσματα Έρευνας για τη Μαιευτική Βία στην Κυπριακή Δημοκρατία*, http://www.familyviolence.gov.cy/upload/20240115/1705314704-01871.pdf

[109] Sample of 8,866 women, 2021, in Mena-Tudela D., Iglesias-Casás S., González-Chordá V. M., Cervera-Gasch A., Andreu-Pejó L., Valero-Chilleron M. J., *Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences*, https://www.mdpi.com/1660-4601/18/1/199

[110] Sample of 60, 2019, in Report on the Mistreatment and violence against women in reproductive health care and childbirth in Finland, A response to the call for submissions by the OHCHR-UN, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf

[111] Sample of 5 million, 2017, in *Doxa-OVOItalia Survey, Observatory on Obstetric Violence Italy - OVOItalia)*, https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/

[112] Sample of 2,079 women, 2022, in Amyx M., Philibert M.,Farr A., Donati S., Smárason A. K., Tica V., Velebil P., Alexander S., Durox M., Fernandez Elorriaga M., Heller G., Kyprianou T., Mierzejewska E., Verdenik I., Zīle-Velika I., Zeitlin J., for the Euro-Peristat Research Group, *Trends in caesarean section rates in Europe from 2015 to 2019 using Robson's Ten Group Classification System: A Euro-Peristat study*, 01 October 2023, https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.17670?af=Rhttps://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-022-01460-4

Form of obstetric violence	Prevalence
	PL: 73.8% of respondents had limited skin-to-skin contact immediately after the birth[113].
No birth companion allowed	ES: 27.9% were not allowed a birth companion[114]. FI: 32% of women suffered emotional abuse, including being left alone during birth without support[115].
Discrimination	DE: Some kind of discrimination (for one or more reasons) was reported by 49.6% of women; 43.2% were treated poorly because of a difference in opinion with their caregivers about the right care for themselves or their baby; 18.2% felt discriminated against or had difficulties understanding the language the care provider used in obstetric care. Women also felt discriminated against for personal characteristics like age (10.1%), high BMI (10.6%) or/and race, ethnicity, cultural background or language (5.1%)[116]. PL: 25% of respondents felt they were treated worse because of age and 14% felt they were treated worse because of their body weight[117].
No privacy	DE: 32.7% had their physical privacy violated in obstetric care[118].

[113] Sample of 8,378 women, 2018, in *Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet*, https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

[114] Sample of 8,866 women, 2021, in Mena-Tudela D., Iglesias-Casás S., González-Chordá V. M., Cervera-Gasch A., Andreu-Pejó L., Valero-Chilleron M. J., *Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences,* https://www.mdpi.com/1660-4601/18/1/199. Note: this study was carried out between January 2018 and June 2019, and therefore the results are not affected by COVID-19.

[115] Sample of 60, 2019, in Report on the Mistreatment and violence against women in reproductive health care and childbirth in Finland, A response to the call for submissions by the OHCHR-UN, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf

[116] Sample of 2,045 women, 2023, in Limmer C. M., Stoll K., Vedam S., Leinweber J., Gross M. M., Measuring disrespect and abuse during childbirth in a high-resource country: Development and validation of a German self-report tool, 2023 Nov:126:103809.doi: 10.1016/j.midw.2023.103809. Epub 2023 Sep 2, https://pubmed.ncbi.nlm.nih.gov/37689053/

[117] Sample of 8,378 women, 2018, in *Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet*, https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

[118] Sample of 2,045 women, 2023, in Limmer C. M., Stoll K., Vedam S., Leinweber J., Gross M. M., *Measuring disrespect and abuse during childbirth in a high-resource country: Development and validation of a German self-report tool*, 2023 Nov:126:103809.doi: 10.1016/j.midw.2023.103809. Epub 2023 Sep 2, https://pubmed.ncbi.nlm.nih.gov/37689053/

Form of obstetric violence	Prevalence
	IT: 19% complain of a lack of confidentiality at various stages and moments of their stay in hospital[119]. PL: over 50% of hospitals were found to have delivery and examination rooms that did not ensure patient's privacy and dignity[120].
Insufficient pain relief	FI: 23% were not given pain relief for overwhelming pain[121]. HR: 37% of women reported that they did not have sufficient anaesthetic for vaginal suturing[122]. PL: 14.6% recall a gynaecological examination in the emergency room as extremely painful and unpleasant[123]. SK: 23.9% of respondents said that sewing maternity injuries or cuts was a very painful procedure. In 14.5% of cases, they were not given an adequate anaesthesia[124].
Restricted movement (no choice of birth position)	ES: 39.5% had their movement restricted[125]. FI: 7% had the position of their second stage of labour dictated to them[126].

[119] Sample of 5 million, 2017, in *Doxa-OVOItalia Survey, Observatory on Obstetric Violence Italy - OVOItalia)*, https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/

[120] Sample of 37 hospitals, 2020, in NIK, *OPIEKA NAD PACJENTKAMI W PRZYPADKACH PORONIEŃ I MARTWYCH URODZEŃ*, https://www.nik.gov.pl/plik/id,23462,vp,26188.pdf

[121] Sample of 60, 2019, in *Report on the Mistreatment and violence against women in reproductive health care and childbirth in Finland, A response to the call for submissions by the OHCHR-UN,* https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf

[122] Sample of 1,287 women, 2020, RODA, in *Rezultati istraživanja Dostupnost zdravstvene skrbi žena tijekom pandemije COVID-19,* https://www.roda.hr/udruga/projekti/zagovaranje-za-zdravstvenu-skrb-zena-temeljenu-na-dokazima-u-doba-pandemije-covid-19/rezultati-istrazivanja-dostupnost-zdravstvene-skrbi-zena-tijekom-pandemije-covid-19.html

[123] Sample of 8,378 women, 2018, in *Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet*, https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

[124] Sample of 3,164 women, 2021, in Patakyová M., Hovorme otvorene o pôrodoch: ľudskoprávny prístup pri poskytovaní zdravotnej starostlivosti pri pôrodoch, https://vop.gov.sk/wp-content/uploads/2021/09/Sprava_porody_FINAL.pdf

[125] Sample of 8,866 women, 2021, in Mena-Tudela D., Iglesias-Casás S., González-Chordá V. M., Cervera-Gasch A., Andreu-Pejó L., Valero-Chilleron M. J., *Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences,* https://www.mdpi.com/1660-4601/18/1/199

[126] Sample of 60, 2019, in Report on the Mistreatment and violence against women in reproductive health care and childbirth in Finland, A response to the call for submissions by the OHCHR-UN, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf

Form of obstetric violence	Prevalence
	PL: 23% of women were not allowed to walk or change position during childbirth[127]. SE: 35.4% were not given a choice of birth position[128].

3.1.2. Limited data on prevalence rates of gynaecological violence

The vast majority of studies identified were concerned with obstetric violence while very few addressed the prevalence rates of gynaecological violence, therefore contributing to the invisibility of this form of violence. Of those studies that were identified, the prevalence rates of gynaecological violence are as follows:

Data collected in abortion clinics in the **Netherlands** and **Spain** from 2017 to 2019 show that pregnant women travelled to these destination countries from other European countries after learning they were pregnant and had exceeded local gestational age (GA) limits[129]. One of the reasons for exceeding local GA limits were misinformation by health professionals about pregnancy signs. A third of respondents had considered abortion while within the GA limits in their country of residence but reported being delayed by difficulties in accessing information on abortion services in their area, or in obtaining a referral to a provider. In a few cases, doctors miscalculated GA, misleading people into thinking they had more time than they did. In Italy, some participants said they were refused care.

In **Spain**, of a sample of 17,541 women surveyed, 45.9% answered that they were neither informed about the procedures they were about to undergo nor expressly requested to provide informed consent. Of these, 74% indicated gynaecologists as the professional responsible for not informing them or requesting their informed consent[130].

In **Poland**, a study found that 71.8% of the activities performed during gynaecological examinations were not gentle enough, and 14.6% recall a gynaecological examination in the emergency room as extremely painful and unpleasant[131].

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127 Sample of 8,378 women, 2018, in *Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet*, https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

128 Sample of 4,528 women, 2022, in Zaigham M., Linden K., Sengpiel V., Mariani I., Pessa Valente E., Covi B., Lazzerini M., Elden H., or the IMAgiNE EURO Study Group, *Large gaps in the quality of healthcare experienced by Swedish mothers during the COVID-19 pandemic: A cross-sectional study based on WHO standards,* Women and Birth Volume 35, Issue 6, November 2022, Pages 619-627, https://www.sciencedirect.com/science/article/pii/S1871519222000105?via%3Dihub

129 De Zordo, S., Mishtal, J., Zanini, G. & Gerdts, C. *Consequences of Gestational Age Limits for People Needing Abortion Care During the COVID-19 Pandemic*, Sexual and Reproductive Health Matters, 2020, 28(1): 1818377.

130 Mena-Tudela D., Iglesias-Casás S., González-Chordá V. M., Valero-Chillerón M. J., Andreu-Pejó L., Cervera-Gasch Á., *Obstetric Violence in Spain (Part III): Healthcare Professionals, Times, and Areas,* International journal of environmental research and public health, 2021, 18(7), 3359. https://doi.org/10.3390/ijerph18073359

131 Sample of 8,378 women, 2018, in *Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet*, https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

3.2. Understanding women's experiences through qualitative research

A number of qualitative studies that detail women's experiences of obstetric violence have been collected across Europe. Those studies are often based on a limited number of in-depth interviews with women.

Several qualitative analyses have been conducted based upon testimonies of women who contributed to several campaigns. For example, an academic thesis conducted in **Germany** analysed the stories of 20 women, some of whom were accessed through the public database of women's experiences via the Roses Revolution[132]. The different types of obstetric violence identified were unresponsiveness, plain mistreatment, withholding information and contact, violating boundaries, and systemic issues, which were said to be influenced by cultural tropes such as the 'overly emotional woman trope', the 'mother-over-human trope' and the 'untouchable doctor trope'.

Another qualitative analysis was carried out based on the stories of women shared in the #breakthesilence campaign of the Birth Movement in the **Netherlands**. A total of 438 stories were investigated, including situations of ineffective communication, loss of autonomy and lack of informed consent and confidentiality. The overarching theme identified was 'Left Powerless' to describe how women felt that power was taken away from them, or they experienced difficulties maintaining control because of the violence they experienced[133].

In addition, common features of the testimonies of 60 women who contributed to the Me Too during Childbirth campaign in **Finland** included a loss of self-determination, complete transfer of decision-making authority to medical staff, experiencing agonising and uncontrolled pain, instrumental delivery that was experienced as violent, enduring severe tearing, lacking support, and being left alone during moments of unbearable pain. It was also found that women are regularly denied the right to refuse interventions within the maternal healthcare system, particularly in the postpartum doctor visit. Women are often told that unless a vaginal examination is performed, they will not be eligible to receive maternity benefits by the state[134].

A non-governmental organisation in **Bulgaria** also collected over 25 women's narratives about their experience of psychological, physical and sexual violence during obstetric consultations and the use of non-consensual and non-medically necessary harmful procedures[135]. These narratives revealed instances where women were insulted, hit, infantilised, starved, ignored, denied pain medication, and had information withheld from them about their child. Through sharing their stories, women hope that the medical system will change to recognise women's humanity.

Besides analyses conducted on women's experiences collected during campaigns, several academic works have been published that analyse women's experiences of obstetric and gynaecological violence. A master's thesis qualitatively assessed women's experiences of obstetric violence in

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[132] Reuther, M. L. *Obstetric Violence Experiences of Birth Givers in Germany: A Thematic Analysis of Birth Stories*, Master's Thesis, University of Twente, 2022, http://essay.utwente.nl/93380/1/reuther_MA_bms.pdf

[133] Van der Pijl M., Klein Essink M., van der Linden M.., et al., Consent and Refusal of Procedures During Labour and Birth: A Survey Among 11 418 Women in the Netherlands, BMJ Quality & Safety, 2023, 1-12.

[134] Immonen K., Lehtila S., Mitchell A., Dykstra, U., Report on the Mistreatment and Violence Against Women During Reproductive Health Care and Childbirth in Finland: A Response to the Call for Submissions by the OHCHR-UN, 2019, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf

[135] Mama Ninja, *Родилките разказват* (The women in labour tell their stories), 2018, https://mamaninja.bg/

Greece[136]. Through an online survey, 63 participants reported the following: the unjustifiable and unnecessary use of various techno-medical interventions (such as artificial induction of labour, artificial breaking of the waters and oxytocin administration); continuous vaginal examinations; being tied to a bed; prohibition of movements; refusal to provide anaesthesia and/or pain relief; the use of forceps and the Kristeller manoeuvre (fundal pressure); the husband's stitch; and verbal abuse (ironic, derogatory and insulting comments).

In **France**, several recent qualitative studies have described the violence suffered by women during gynaecological consultations[137], with one study involving 70 interviews with patients, 31 interviews with healthcare professionals and observing 95 gynaecological consultations. It has been shown that the medical establishment exercises control over women's reproductive bodies from adolescence until the end of life, and that women rarely leave these "gynaecological careers" (called "careers" because they are considered to be the real work carried out by women to comply with contraceptive standards and risk prevention). The pain associated with the female body is internalised and naturalised from an early age. This research has also shown how women experience racial injustice during their gynaecological care, are not asked for their consent, and how overwork in hospitals leads to repetitive, automatic procedures that dehumanise women and are a risk factor for gynaecological violence.

3.3. The impact of institutional structures on prevalence of obstetric and gynaecological violence

In addition to increased medicalisation, another important factor that explains the high prevalence of forms of obstetric and gynaecological violence is the organisational structures of healthcare systems.

Bénédicte Coulm showed that in **France**, among women with low obstetric risk, practices such as caesarean section or episiotomy are more frequent in private than public healthcare facilities[138]. Factors contributing to this outcome include fear of malpractice litigation that may be greater in private units, which is particularly pertinent in France where lawsuits are filed against the obstetrician in private hospitals but against the hospital in public ones. Moreover, women in private facilities may expect greater access to interventions such as c-sections and induction, and obstetricians may be more sensitive to their requests since they are the primary care practitioners throughout the patient's pregnancy, while deliveries in French public hospitals are attended by the team on duty. The organisation of healthcare delivery in private hospitals could also be another contributing factor. For example, in private hospitals, obstetricians attend the birth of their patients alongside seeing other patients; therefore, these constraints mean that induction of labour or c-sections could facilitate time management. In addition, while in private hospitals, obstetricians make all decisions about procedures

[136] Kiriaki A. *The Experience of Childbirth in Public Hospitals. Investigation of the phenomenon of obstetric violence in Greece*, 2021, https://apothesis.eap.gr/archive/item/92128

[137] Fonquerne L., C'est pas la pilule qui ouvre la porte du frigo ! Violences médicales et gynécologiques en consultation de contraception, Sante Publique, 2021, 33 (5): 663-73;
Koechlin A., La norme gynécologique: ce que la médecine fait au corps des femmes. Paris: Éditions Amsterdam, 2022;
Roux A., *Pilule: Défaire l'évidence*, s. d. Éditions de La Maison Des Sciences de l'homme. Consulté le 26 février 2024, https://www.editions-msh.fr/livre/pilule-defaire-levidence/

[138] Coulm B., Le Ray C., Lelong N., Drewniak N., Zeitlin J., Blondel, B., *Obstetric Interventions for Low-Risk Pregnant Women in France: Do Maternity Unit Characteristics Make a Difference?*, Birth, 2012, 39(3): 183-91. https://onlinelibrary.wiley.com/doi/10.1111/j.1523-536X.2012.00547.x

during labour, in public units, low-risk deliveries are attended by midwives who are less in favour of interventions than obstetricians.

Higher rates of c-sections were also observed in private hospitals (36.4%) compared to public hospitals (24.2%) in **Catalonia** (**Spain**)[139]. More births are induced in private hospitals because women are linked to a specific gynaecologist, who needs to be able to deliver at a time that is convenient to him/her. In addition, performing a c-section might be more economically fruitful than attending a vaginal birth. Finally, there are fewer midwives in private hospitals, and they have less autonomy when attending to the births[140].

A study carried out among public hospitals in **Spain** found that the rate of c-sections is higher during the early hours of the night compared to the rest of the day[141]. Similarly, in **Austria**, a study found that obstetricians were less likely to undertake caesarean deliveries on weekends and public holidays and had a greater incentive to perform them on Fridays and days preceding public holidays due to obstetricians' demand for leisure[142]. Therefore, unnecessary medical procedures such as c-sections are a large part determined by the organisational structures of the hospital, including the time of day, costs and other labour demands.

3.4. The impact of COVID-19 on prevalence of obstetric and gynaecological violence

The pandemic has not only had a considerable influence in revealing the prevalence of obstetric and gynaecological violence, but has also accentuated certain forms of this violence (e.g. lack of autonomy and liberty, deshumanisation of care, etc.) and increased the prevalence and severity of some other forms (like episiotomy, labour induction, abdominal expression, etc.)[143]. It has also increased unnecessary interventions done without medical indications (such as caesareans or instrumental deliveries)[144]. A substantial amount of the literature identified focused on the impact of the COVID-19 pandemic on the quality of maternal and newborn care.

In **France**, the COVID-19 pandemic has revived controversy about obstetric violence, with the denunciation of two practices observed during childbirth in certain establishments: the imposition of the wearing of masks and the refusal to allow some women to be accompanied. The research showed that women were very lonely, with a continuum of loneliness and successive social breakdowns: the cancellation of birth and parenthood support sessions, lack of recognition of the social status of

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139 Escuriet P. R., Trespalacios E. X., Morros Serra, M., Alcaraz Vidal, L., Brigidi, S., Bueno Lopez, V., et al. *Pla per a l'abordatge de la violència obstètrica i la vulneració dels drets sexuals i reproductius (2023–2028).* Barcelona: Generalitat de Catalunya; 2023.

140 Ibid.

141 Costa-Ramón A. M., Rodríguez-González A., Serra-Burriel M., & Campillo-Artero C. *It's About Time: Cesarean Sections and Neonatal Health*, Journal of Health Economics, 2018, 59, 46–59. https://www.sciencedirect.com/science/article/pii/S0167629617307609?via%3Dihub

142 Halla M., Mayr H., Pruckner G. J., García-Gómez P., *Cutting Fertility? Effects of Cesarean Deliveries on Subsequent Fertility and Maternal Labor Supply*, Journal of Health Economics, 2020, 72, 102325.

143 De Zordo S., Zanini G., Mishtal J., Garnsey C., Ziegler A. K., Gerdts C. *Gestational Age Limits for Abortion and Cross-Border Reproductive Care in Europe: A Mixed-Methods Study*, BJOG: An International Journal of Obstetrics and Gynaecology, 2021, 128(5), 838–845. https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16534

144 Sadler M, Leiva G, Olza I, *COVID-19 as a risk factor for obstetric violence*, Sex Reprod Health Matters. 2020 Dec;28(1), https://pubmed.ncbi.nlm.nih.gov/32552522/

'pregnant woman', absence of a partner during pre-labour and/or childbirth, and the 'descent into hell' described in the post-partum period[145]. Giving birth in a midwife-led birthing centre rather than in a hospital was a protective factor as this enabled the emotional and family dimension of childbirth to be preserved[146].

The IMAgiNE Euro project was one of the main research endeavours that exposed the prevalence of obstetric and gynaecological violence in the context of the COVID-19 pandemic. The project aimed to investigate and map maternity and neonatal care preparedness, quality and opportunities during phases of the COVID-19 pandemic across 15 European countries[147]. This project involved two web-based, anonymous surveys—one for women who gave birth and one for healthcare professionals. The findings of this project not only shed light on the barriers and difficulties for women to access basic antenatal and gynaecological services and receive proper care during the pandemic, but also exposed normalised practices involving a lack of consent, inadequate support and abuse.

In the framework of the IMAgINE project, one study focused on the quality of maternal and neonatal care during the COVID-19 pandemic in **Portugal**[148]. It found that, among the 1,845 women who answered the questionnaire, 66.2% had limitations imposed regarding the presence of a companion of choice due to COVID-19 restrictions, but also that 62.2% did not have their consent requested for the use of instruments; 38.1% did not receive emotional support, 31.9% were not always treated with dignity; and 23.3% felt victims of physical/verbal/emotional abuse.

Similarly, in **Latvia**, the study found that out of the 1,860 women who completed the online questionnaire, 66.4% of women received fundal pressure in an instrumental vaginal birth, 43.5% lacked involvement in choices, 17.4% reported suffering abuse, 32.7% reported inadequate breastfeeding support while 5.2% lack of early breastfeeding[149].

Another study under the IMAgiNE Europe project was carried out in **Sweden**. Of the 4,528 women that gave birth during the pandemic, 46.7% perceived a poorer quality of maternal and newborn care due to COVID-19[150]. In addition, no consent was requested in 36% of instrumental vaginal births, 36.8% received inadequate breastfeeding support, 18.4% of women felt that they were not treated with dignity and 6.9% reported some form of abuse.

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145 Rozée, V. & Schantz, C. *Accoucher pendant la pandémie du Covid-19 en France: d'un tout s'est bien passé au sentiment d'une maternité volée,* Sciences Sociales et Santé, 2023, 41(4): 43-70. https://doi.org/10.1684/sss.2023.0259.

146 Schantz, C., Tiet M., Evrard A., Guillaume S., Boujahma D., Quentin B., Pourette D., Rozée V., *A strong capacity to face the shock of the health crisis: MaNaO, a midwife-led birthing centre in France*, 2023, Midwifery.

147 Italy, Sweden, Great Britain, Ireland, France, Germany, Portugal, Spain, Norway, Slovenia, Romania, Serbia, Luxembourg and Croatia.

148 Costa R., Barata C., Dias H., Rodrigues C., Santos T., Mariani I., Covi B., Pessa Valente E., Lazzerini M., IMAgiNE EURO study group, *Regional Differences in the Quality of Maternal and Neonatal Care During the COVID-19 Pandemic in Portugal: Results from the IMAgiNE EURO Study*, International Journal of Gynaecology and Obstetrics, 2022, 159, 137-153.

149 Pumpure E., Jakovicka D., Mariani, I, Vaska A., Covi B., Pessa Valente E., Jansone-Santare G., Regina Knoka, A., Paula Vilcane K., Rezeberga D., Lazzerini, M. & the IMAgiNE EURO study group, *Women's Perspectives on the Quality of Maternal and Newborn Care in Childbirth During the COVID-19 Pandemic in Latvia: Results From the IMAgiNE EURO Study on 40 WHO Standards-Based Quality Measures*, International Journal of Gynaecology and Obstetrics, 2022, 159, 97-112.

150 Zaigham, M., Linden, K., Sengpiel, V., Mariani, I., Pessa Valente, E., Covi, B., Lazzerini, M., Elden, H. & the IMAgiNE EURO study group. *'Large Gaps in the Quality of Healthcare Experienced by Swedish Mothers During the COVID-19 Pandemic: A Cross-Sectional Study Based on WHO Standards'*, Women Birth, 2022, 35(6), 619-627.

Other studies conducted on women's experiences of obstetric care during the COVID-19 pandemic include a study carried out in **Slovakia**[151]. This study, which surveyed 184 women who suffered human rights violations during antenatal and childbirth care, found that these violations not only persisted during the first wave of the pandemic, but they were often either much more severe or acquired new forms. Examples included not allowing women in childbirth to have a companion of their choice present, denying women and their babies skin-to-skin contact directly after delivery and a denial of pain relief.

A study carried out on abortion policies during the outbreak of the pandemic in Europe found that, during COVID-19, abortions (that were banned in two Member States, Malta[152] and Poland[153]) were suspended in one (Hungary) due to a ban on non-life-threatening surgeries in state hospitals[154]. In Poland, the parliament discussed additional restrictions to ban abortion for foetal anomalies in April 2020 but deferred a final decision. Abortion care was not available for women who had COVID-19 symptoms or were living with someone with symptoms in the Netherlands, while five Member States (BE, DE, LV, LU, SI) suggested abortion care was to be delayed in symptomatic women or those that tested positive. Finally, no country expanded its gestational limit for abortion.

3.5. Adopting an intersectional approach to identify women most at risk

Studies have demonstrated that certain women are more at risk of experiencing this form of violence than others due to the combination of gender biases with other grounds of discrimination (such as social status, gender identity, sexual orientation, disability and/or age), or due to the fact that they do not correspond to gender norms defining what a 'good woman' is or should be (e.g. women who deviate from the dominant social norms of "good motherhood" because they are considered to be too young, too old, not in a stable heterosexual couple, unemployed, etc.).

Some of the gynaecological and obstetric techniques that are used today have their historical roots in experimental surgeries used on powerless women who did not consent[155]. Those underpinned conceptions that some women bear more pain based on their race, class or other social constructs, which in today's lexicon has been termed 'obstetric hardiness'[156] to capture how marginalised women and women in situations of vulnerability tend to face far more obstetric and gynaecological mistreatments than other women. Obstetric racism also persists, leading to disparities in access to life-

[151] Občan, demokracia a zodpovednosť and Ženské kruhy. Monitoring Report on Violations of the Human Rights of Women in the Provision of Childbirth Care in Healthcare Facilities in Slovakia During the COVID-19 Pandemic, 2021, http://odz.sk/en/wp-content/uploads/porod-prava-pandemia_EN_web.pdf

[152] Although, abortion was illegal in Malta without exception until 2023, when legislation was approved to allow abortions but only in cases where the life of the pregnant woman is at risk.

[153] However, as of January 27th, 2021, abortion in Poland is illegal except in cases where the pregnancy is a result of a criminal act or when a woman's life is in danger.

[154] Moreau, C., Shankar, M., Glasier, A., Cameron, S., & Gemzell-Danielsson, K., *Abortion Regulation in Europe in the Era of COVID-19: A Spectrum of Policy Responses*. BMJ Sexual & Reproductive Health, 2021, 47(4), e14-e14.

[155] Wall L. L., *The Medical Ethics of Dr J Marion Sims: A Fresh Look at the Historical Record*, Journal of Medical Ethics, 2006, 32(6), 346–350. https://jme.bmj.com/content/32/6/346

[156] Davis D-A. *Reproductive Injustice: Racism, Pregnancy and Premature birth*. 2019, New York: NYU Press. https://doi.org/10.18574/nyu/9781479812271.0

saving medical technology and pain relief for Black mothers, contributing to higher rates of maternal and infant mortality, as well as increased morbidities related to pregnancy and childbirth[157].

Research carried out in the framework of this study identified the following groups or factors as most likely to face this form of violence:

- **Migrants**

Results from a study under the IMAgiNE EURO project revealed the quality of care provided to migrant compared to non-migrant women with data from 11 countries, including **Germany, France, Italy, Croatia, Luxembourg, Portugal, Sweden, Slovenia**[158]. The data show that migrant women faced obstetric violence at a higher rate compared to non-migrant women, such as in barriers in accessing facilities (32.9% vs 29.9%), not receiving timely care when arriving at the facility (14.7% vs 13.0%), not being allowed to stay with their baby as they wished (7.8% vs 6.9%), and more likely to suffer physical/verbal/emotional abuse (14.5% vs 12.7%)[159].

Research carried out in **Czechia** found that migrant women were very critical of the care they received in maternity hospitals. They described insufficient access to health insurance, an absence of social support, language barriers as well as prejudice from doctors[160].

Research on immigrant women from sub-Saharan Africa shows that they receive obstetrical care of lower quality in **France**. This includes care which is not based on the latest scientific evidence, and which does not take into account the context in which the women find themselves, their background, their wishes, or even the organisation of maternity and the expertise of the caregiver. It also notes the prevalence of c-sections, to which women from sub-Saharan countries are very exposed, of the order of 35% compared to 20% for the general population[161].

A study carried out among women living in a refugee camp near Athens (**Greece**) showed that all interviewed women (29) reported a lack of informed consent during antenatal and intrapartum care[162]. Migrant women also reported discriminations during gestation or delivery, life-threatening complications due to denied/delayed/insufficient assistance, and even miscarriages due to denied assistance. In addition, they reported a lack of and/or a delayed access to information, either because it is unavailable or because they are not provided with any translation support[163].

Asylum-seekers arriving to **Hungary** from Serbia are placed in the transit zones at the Southern border of Hungary. If a woman starts labour in the transit zone, she is taken to the nearest hospital by

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157 Shadwick R. *The Battle for Recognition: Obstetric Violence and its Long Controversies*, 2021, https://www.durham.ac.uk/research/institutes-and-centres/ethics-law-life-sciences/about-us/news/obstetric-violence-blog/battle-for-recognition-of-obstetric-violence/

158 Other non-EU-27 countries were Norway, Switzerland and Serbia.

159 IMAgiNE EURO study group, Quality of Maternal and Newborn Care Around the Time of Childbirth for Migrant Versus Nonmigrant Women During the COVID-19 Pandemic: Results of the IMAgiNE EURO Study in 11 Countries of the WHO European Region. International Journal of Gynaecology and Obstetrics, 2022, 159(Suppl 1):39-53.

160 Pařízková A., Hrešanová E., Glajchová A., Migration and childbirth: An Intersection of Two life changes in Social-Science research on Women's Health, Czech Sociological Review, 2018, 54 (1).

161 Sauvegrain P., *So-Called "Gynecological and Obstetrical" Violence Against Immigrant Women From Sub-Saharan Africa in France*, Santé Publique, 2022, 33(5):627-628.https://www.cairn.info/revue-sante-publique-2021-5-page-627.htm

162 Avramidou, I.A. *The Maternity System and the Birth Choices of Women in Greece*, 2013. Birthrights in Greece. http://forbirth.blogspot.com/2013/11/the-maternity-system-and-birth-choices.html

163 Birth rights in Greece, http://forbirth.blogspot.com/

ambulance, without any accompanying person. Usually, no interpretation is available during their care, in which cases they cannot give their informed consent to any procedures done, including a c-section, and the woman cannot make her needs heard either during labour or birth[164].

A study carried out on data from 122 police files regarding suspected cases of female genital mutilation found that African, mainly Somali, girls in **Sweden** are subject to compulsory genital examinations. While the ultimate aim is to protect girls at risk of female genital mutilation, the coercive measures deployed, sometimes without consent and in which the girls found humiliating and invasive, resulted in trauma for some of the girls involved[165].

- **Race, ethnicity and religion**

Research carried out by a non-profit organisation in **Portugal** on the experiences of black and Afro-descent women was conducted between March 2021 and June 2023[166]. It was found that more than 24% reported having suffered obstetric violence during childbirth. Specifically, 23.4% reported feeling neglected, 19.7% felt disrespected and 17% were humiliated.

The regional survey carried out by the Citizen Platform for a Respected Birth (*Plateforme citoyenne pour une naissance respectée*),[167] in **Belgium** found that 1 out of 3 women of colour experienced some form of obstetric violence (compared to the general average of 1 in 5)[168].

Amal's Women's Association[169] investigated Muslim women's experiences of maternity care in **Ireland**, finding concerning manifestations of obstetric violence and racism, particularly towards migrant Hijab wearing women. In addition to the structural barriers to accessing healthcare that have been documented in the literature (such as socioeconomic, geographic and/or cultural barriers, languages issues, etc.), general negative attitudes, harmful stereotyping, erroneous assumptions about pain tolerance, and individual acts of racism and bigotry meant that many women did not use the services to the same extent as their white counterparts; in fact, only 21% attended antenatal classes[170]. Still, in **Ireland**, the Confidential Maternity Death Enquiry[171] found a five-fold difference in maternal mortality rates amongst women from Black Ethnic backgrounds and an almost two-fold difference amongst women from Asian Ethnic backgrounds compared with white women[172].

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164 OHCHR Submission on the issue of Mistreatment and violence against women during reproductive health care with a focus on childbirth, as the subject of the next thematic report of the United Nations Special Rapporteur on violence against women.

165 Johnsdotter S., *Meaning Well While Doing Harm: Compulsory Genital Examinations in Swedish African Girl'*, Sexual and Reproductive Health Matters, 2019, 27:2, 87-99, DOI: 10.1080/26410397.2019.1586817

166 Afrolis, *SaMaNe Shares First Study on Obstetric Racism in Portugal*, 2023, https://afrolis.pt/samane-partilha-primeiro-estudo-sobre-racismo-obstetrico-em-portugal/

167 https://www.naissancerespectee.be/

168 Citizen Platform for a Respected Birth, *Giving Birth in Brussels and Wallonia Before and During COVID – The Results*, 2022, https://www.naissancerespectee.be/accoucher-a-bruxelles-et-en-wallonie-avant-et-pendant-le-covid-les-resultats/

169 https://www.amalwomenirl.com/

170 Belacy, N. *'Same Story, Different Country – The Experiences of Muslim Women in Irish Maternity Hospitals'*, 2023, https://www.durham.ac.uk/research/institutes-and-centres/ethics-law-life-sciences/about-us/news/obstetric-violence-blog/experiences-of-muslim-women-in-irish-maternity-hospitals/

171 https://www.ucc.ie/en/mde/

172 MDE Ireland. *'Confidential Maternal Death Enquiry Ireland'*, 2021, https://www.ucc.ie/en/media/research/maternaldeathenquiryireland/NPEC_MDEDataBriefNo5_Nov2021.pdf

A study carried out by the civil society organisation, European Roma Rights Centre, studied the issues encountered by Romani women in maternity wards in **Bulgaria**[173]. The report found several common practices: placing Romani women in ethnically segregated maternity wards in certain public hospitals; the medical staff of these hospitals paying less professional attention to the Romani women and newborns; verbal insults against Romani mothers, in many cases, during labour and delivery; lack of proper information provided by medical staff and Romani women signing documents in the hospital without understanding the content of those documents; being immobilised during delivery; subject to physical abuse; and no anaesthesia provided for perineal stitches.

In **France**, research carried out in the obstetric and gynaecological service of a Parisian public hospital shows the negative impact of racial/ethnic representations of healthcare professionals on patients they identify as Roma, in terms of quality of care and types of treatments they receive[174].

The Centre for Reproductive Rights interviewed 38 Roma women on their experiences of reproductive healthcare in **Slovakia**. They reported accounts of abuse and discrimination, including, segregation in maternity care departments, racial harassment and humiliation, neglect, physical restraint and abuse during childbirth, and failures related to informed consent and decision-making with regard to medical treatment[175].

Research carried out in **Czechia** and **Slovakia** highlights the issue of the sterilisation of Romani women without their free and informed choice and consent[176].

Academic research carried out in **Ireland** shows that Traveller women experienced neglect, abandonment, non-consensual treatment, delays in medical treatment and discrimination in obstetric settings[177].

In the public hospital of Miskolc in **Hungary**, a *de facto* segregation occurs after childbirth, with Roma and non-Roma women placed in separate wards due to informal practices driven by cultural differences. The hospital acknowledges the issue but has not implemented institutional changes to address this segregation. The hospital in question prevents Roma and socioeconomically disadvantaged women from exercising their right to be accompanied during childbirth by charging a high fee for the required 'visitor attire,' (a disposable hygienic suit to be worn in the delivery room by the companion of the woman) making it unaffordable for impoverished families and leading to many Roma mothers to endure labour without a supportive companion[178].

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173 The European Roma Rights Centre. '*Cause of Action: Reproductive Rights of Romani Women in Bulgaria*, 2020, http://www.errc.org/reports--submissions/cause-of-action-reproductive-rights-of-romani-women-in-bulgaria

174 Prud'homme, D. 'Du soin global au traitement discriminatoire, La prise en charge de patientes identifiées comme roms dans un service de gynécoobstétrique parisien', ENS Paris-Saclay Terrains & travaux, 2016, 29(2), https://www.cairn.info/revue-terrains-et-travaux-2016-2-page-85.html

175 Centre for Reproductive Rights. '*Vakeras Zorales – Speaking Out: Roma Women's Experiences in Reproductive Health Care in Slovakia*', 2017, https://reproductiverights.org/sites/default/files/webform/GLP-SlovakiaRomaReport-Final-Print.pdf

176 Albert, G. '*Forced Sterilisation as Antigypsyism: The Czechoslovak/Czech and Slovak Examples*', 2019, https://www.dzaniben.cz/files/61967a82bcc774a24dfa79aed858271c.pdf#page=21

177 Kavanagh, L. '*Standing Alongside' and in Solidarity with Traveller Women: Minority Ethnic Women's Narratives of Racialized Obstetric Violence*. PhD thesis, National University of Ireland Maynooth, 2018.

178 OHCHR Submission on the issue of Mistreatment and violence against women during reproductive health care with a focus on childbirth, as the subject of the next thematic report of the United Nations Special Rapporteur on violence against women.

- **Physical characteristics like weight**

Research in **Poland** show that 14% of overweight women felt they were treated worse in obstetric care because they were overweight[179].

A study carried out in **France** found that women with a high BMI were more likely to receive no or an inappropriate gynaecological check-up[180].

- **Women with disabilities**

The non-profit organisation Women and Health (*Femmes & Santé)*[181], the Disability and Sexuality Resource Centre[182] (*Handicap et Sexualités)* and the Disability and Health (*Handicap et Santé*)[183] project published a report on obstetric and gynaecological violence experienced by women with intellectual disabilities living in institutions in **Belgium**[184]. These women suffered from obstacles to respectful care and did not have their consent or choices respected.

- **Deviation from gender norms and sexual orientation**

A policy paper conducted in **Germany** found that 53.6% of trans men and non-binary individuals reported discrimination during pregnancy and childbirth compared to 21.4% of cisgender people[185]. Trans and intersex individuals also reported receiving less access to information relevant to them concerning pregnancy and birth compared to cisgender endosex individuals.

Qualitative research on 12 transmasculine[186] people in **Sweden** undergoing pregnancy and childbirth reported feeling excluded and ignored in antenatal care, were denied privacy during delivery and were fearful of potential sterilisation[187].

According to the EU LGBT survey conducted by FRA, one in ten of the respondents who had accessed healthcare services in the year preceding the survey reported that they had felt personally

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179 Fundacja Rodzic po Ludzku. *Report on monitoring maternity wards. Perinatal care in Poland in the light of women's experiences*, 2018, Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet (rodzicpoludzku.pl)

180 Franck, J., Ringa, V., Rigal, L., et al. *Patterns of gynaecological check-up and their association with body mass index within the CONSTANCES cohort*, Journal of Medical Screening, 2021, 28(1):10-17. doi:10.1177/0969141320914323

181 https://www.femmesetsante.be/

182 http://www.handicaps-sexualites.be/

183 http://www.handicap-et-sante.be/

184 El Konnadi, S., Jacquet, M. & Rollin, L. Violences gynécologiques et obstétricales vécues par les femmes avec une déficience intellectuelle vivant en institution : Étude exploratoire sur la situation en Belgique francophone, 2020, https://assets.ctfassets.net/10gk3lslb1u3/2vcluHLvfLz8ft5GYjhsrt/96a054afc2e4de6e2ceee73c485d1e3d/rapport_VGO-web.pdf

185 Von Ska Salden & Dem Netzwerk Queere Schwangerschaften. *Queer und schwanger Diskriminierungserfahrungen und Verbesserungsbedarfe in der geburtshilflichen Versorgung*, 2022, https://www.gwi-boell.de/sites/default/files/2022-02/E-Paper

186 A transmasculine person is a person who was assigned female at birth and whose gender identity and/or gender expression is male.

187 Felicitas, F., Frisén, L., Dhejne, C. & Armuand, G. 'Undergoing Pregnancy and Childbirth as Trans Masculine in Sweden: Experiencing and Dealing with Structural Discrimination, Gender Norms and Microaggressions in Antenatal Care, Delivery and Gender Clinics', International Journal of Transgender Health, 2021, 22:1-2, 42-53, DOI: 10.1080/26895269.2020.1845905

discriminated against by healthcare personnel[188]. Stereotypes and prejudices linked to sexuality and gender lead to a very low rate of gynaecological consultations, whether for preventive or curative purposes. As a result, lesbians are not routinely offered cervical cancer screening, being considered a low-risk group[189], and in general are more exposed than heterosexuals to the risks linked to STIs.

- **Age**

Data on young women who gave birth in **Poland** show that 25% felt they were treated worse because of their age[190].

[188] European Union Agency for Fundamental Rights. *European Union Lesbian, Gay, Bisexual and Transgender Survey*, 2013, https://fra.europa.eu/sites/default/files/eu-lgbt-survey-results-at-a-glance_en.pdf

[189] Go To Gyneco, https://gotogyneco.be/projet/

[190] Fundacja Rodzic po Ludzku, *Report on monitoring maternity wards. Perinatal care in Poland in the light of women's experiences*, 2018, https://rodzicpoludzku.pl/raporty/raport-z-monitoringu-oddzialow-polozniczych-opieka-okoloporodowa-w-polsce-w-swietle-doswiadczen-kobiet/

4. PUBLIC AWARENESS AND ATTITUDES TOWARDS OBSTETRIC AND GYNAECOLOGICAL VIOLENCE

Key findings

Obstetric and gynaecological violence is a relatively new concept and research has shown that women victims of obstetric and gynaecological violence often experience difficulties to name and understand it as such.

However, over the past years, significant work has been carried out by civil society organisations to raise awareness on this form of gender-based violence.

Throughout Europe, a number of initiatives (some of those spearheaded by healthcare professionals themselves) have also flourished through social networks to collect women's experiences of obstetric and gynaecological violence and have contributed to placing the issue on the policy and societal agenda.

4.1. Initiatives to raise awareness on the issue have been identified in the majority of EU 27 MS

Initiatives to raise awareness and denounce obstetric violence have been found in the majority of Member States, with a few limited exceptions. These initiatives mostly consist of communications campaigns organised by civil society organisations to provide women with information on their rights during pregnancy and childbirth.

Most identified initiatives have focused on obstetric violence, and less information has been found on initiatives focusing on gynaecological violence. However, some more recent campaigns to address issues related to gynaecological violence have been identified in a limited number of Member States.

Initiatives to 'empower' women and help them know their rights have been identified and include examples such as the 'It´s enough!' (*Už dost!*) in **Czechia**, an initiative of non-profit organisations dedicated to the issue of obstetric violence. The website provides information about what obstetric violence is, how it manifests itself and how women can protect themselves. Stories of women having experienced obstetric violence are published on the website as well[191].

In **Romania**, between 2021 and 2023, a campaign was implemented on the rights to health and safety in which 24 events[192] were held, including 12 informative sessions on violence against women and maternal and reproductive health and 12 events on mapping women's issues, with some events focusing on informing women about the tools and tactics they can use to exercise their rights and ways to put pressure on the authorities (e.g. hearing with the mayor, petition, protest, etc.). 510 women took part in those events[193]. In **Hungary**, an increasing number of NGOs and grassroot movements have raised awareness on the topic, such as the 'Másállapot' grassroot movement, which started in 2016 (this

[191] "It´s enough!" (Už dost!), https://www.uz-dost.cz/

[192] https://activecitizensfund.ro/in-imagini-centrul-filia-egalitate-de-gen-la-firul-ierbii/

[193] Centrul FILIA (2021) *Annual Report 2021*. Available at: https://centrulfilia.ro/new/wp-content/uploads/2022/07/Annual-Report-2021.pdf

translates to "different state, different condition", which is also a wording used for pregnancy, and also refers to the need for a different state of affairs in maternity care)[194].

A few campaigns have targeted specific groups of women, such as women with disabilities in **Poland**[195], or Roma women in **Slovakia**[196], where there have been several initiatives since 2021 to address the situation of Roma women and forced sterilisation. In 2021-2023, the project "Let's tackle obstetric violence" took place and contributed to establishing centres for victims of obstetric violence and involuntary sterilisation. More than 250 people (health professionals, doctors, midwives and students) were trained in the fields of communication, evidence-based care, and law. Free educational videos were also created.

Interestingly, in some Member States, some campaigns not only targeted women, but also aimed at raising societal awareness on the issue. This was the case in **Portugal**[197], where a national campaign and a survey focusing on reproductive rights and women's experiences were carried out between 2012-2015 and then 2015-2019. The campaign aimed at informing and training civil society, women intending to become pregnant, pregnant women and women who have recently given birth, as well as health professionals, about women's rights during pregnancy, childbirth and the postpartum period. A few other campaigns have targeted specialised stakeholders, such as healthcare (**Poland**) or legal professionals (**Portugal**).

In **Lithuania**, in 2020, NGOs[198,199,200] that work in the field of human rights and women rights initiated a political debate about the unethical and degrading treatment of women in labour and the adverse impact this has on their health caused by possibly inadequate care. The Human Rights Committee of the Parliament of Lithuania issued a proposal for the Ministry of Health that suggested considering the possibility of establishing:

- The concept of obstetric violence in national legislation;
- Legal liability in cases of said violence;
- An independent control mechanism for compliance with ethical principles and ensuring the competencies of medical staff to reduce cases of improper treatment of women in labour;
- A bullying prevention programme in medical institutions to educate health professionals on cases of inappropriate behaviour.

However, so far, these proposals have not been implemented.

194 Másállapotot a Szülészetben!, https://masallapotot.hu/

195 Kulawa Warszawa Foundation, https://www.kulawawarszawa.pl/

196 Poradňa pre občianske a ľudské práva (Consultancy for civil and human rights), https://poradna-prava.sk/en/

197 Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto, https://associacaogravidezeparto.pt/campanhas-e-eventos/experiencias-parto-portugal-2015-2019/

198 Motinystę globojančių iniciatyvų sąjunga, https://mgis.lt/mano-gimdymas/

199 Lietuvos dulų asociacija, https://www.dula.lt/

200 Lietuvos akušerių sąjunga, https://akuseriusajunga.com/

Several NGOs that actively raise awareness about obstetric violence in **Lithuania** created a platform for women to share their experiences, including the Union of Obstetricians of Lithuania[201], the Association of Midwifes of Lithuania[202], and the Union of Maternity Care Initiatives[203].

Associations like Roda Parents in Action[204] a group of engaged citizens that advocates for dignified pregnancy, parenthood and childhood in **Croatia** have collected data on obstetric and gynaecological violence and have denounced it publicly with several campaigns. Interestingly, the number of women reporting this violence increased during these campaigns, which is likely because they feel less stigmatised for doing so. Women have also used social media groups (e.g. women's and parent groups) to discuss their experiences (see Box 2).

An analysis of the titles of the campaigns and other awareness raising initiatives show some evolution in some Member States in the way the issue is being framed, from a healthcare issue to one of violence. For instance, in **Poland**, a succession of campaigns to raise awareness started 20 years ago (2004)[205], which aimed at raising awareness on the existing issues with women patients' rights in maternity wards. However, the first campaign to use the term 'violence' to refer to issues in relation with obstetric violence took place in 2022[206].

In some Member States, those activities have been framed around international events (16 Days of Activism Against Gender-Based Violence) and have used international events to provide visibility and legitimacy to the issue. In **Greece**, in 2020, the campaign 'What is gynaecological and obstetric violence?'[207] was carried out by the OVOHELLAS (Obstetric Violence Observatory Greece) (#ShowRespectNoToViolence) during the 16 Days of Activism Against Gender-Based Violence. During an online campaign, women were called to report incidents of obstetric violence on the website of the organisation. Similarly, in **Ireland**, as part of 2020 16 Days of Activism Against Gender-Based Violence, the campaign looked at the issues of obstetric and reproductive violence, and how these issues apply to people's lives in Ireland and across the globe.

In 2023, in **Luxembourg**, the International Women's Day march addressed the issue of obstetric and gynaecological violence, with specific demands including, among other revindication, the possibility of criminal prosecution and reporting of gynaecological and obstetric violence, and collecting precise and regular statistical data on gynaecological and obstetric violence (through specific surveys and through improved quality management systems of hospitals with gynaecological services[208]).

In addition, ad hoc activities have been held throughout several Member States, contributing to raising awareness and putting the problem on the agenda, including:

- Podcasts on obstetric violence, which drew upon women's stories (Czechia, Latvia[209])

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201 Lietuvos Akušerių Sąjunga, https://akuseriusajunga.com/

202 Lietuvos dulų asociacija, https://www.dula.lt/

203 Motinystę globojančių iniciatyvų sąjunga, https://mgis.lt/

204 RODA, http://www.roda.hr

205 Walczymy o normalność, https://rodzicpoludzku.pl/projekty/walczymy-o-normalnosc/

206 Przemoc położnicza STOP 2022, https://rodzicpoludzku.pl/baza-wiedzy/przemoc-poloznicza-i-ginekologiczna/

207 What is gynaecological and obstetric violence?, https://eimaimaia.gr

208 Platform JIF, *Feminist march of 8th March 2023*, https://fraestreik.lu/nos-revendications-ras-le-viol/

209 Violence occurs in childbirth and its prevention is discussed with Karina Palkova, lecturer at the Faculty of Law of Riga Stradins University, director of the legal science of the doctoral study program, gynaecologists, obstetricians, the chairman of the board of the Riga Maternity Hospital Santa Markova, the midwife of Sigulda Hospital Liena Ceriņa, sworn

- Public events, conferences or debates (Latvia in 2022[210], Lithuania in 2023[211])
- Research from civil society (Latvia[212], Slovakia[213], Italy[214])

Box 2: Awareness raising campaign in Croatia

Roda was founded in 2002 with a petition and demonstration about respectful care in maternity services called *My Body – My Birth – My Choice*[215]. This work was initiated in response to harmful routine practices that were being used in Croatian maternity services, including banning or restricting companionship at childbirth, high percentages of episiotomy, the Kristeller manoeuvre, harmful and violent practices and a lack of consent. The watershed moment came when the broader movement to end gender-based violence and feminist circles realised that some harmful obstetric practices were not medically necessary but were yet another form of institutionalised gender-based violence.

Roda launched the #BreakTheSilence (*#PrekinimoŠutnju*) campaign in 2014. The campaign began on Facebook for the 16 Days of Activism Against Gender-Based Violence, where Roda invited women to write about their experiences and send them on social media. While the Croatian translation of 'obstetric violence' was used (*porodničarsko nasilje*), this term was not well understood by the general public or healthcare workers. In addition, because the term implied only obstetricians are perpetrators (and not other healthcare professionals), a more descriptive term was used in communications—violence against women in pregnancy and childbirth[216].

Initially, the campaign was run by Roda, but over time a small consortium of NGOs in the women's right and reproductive rights space joined and amplified it. In later iterations (2018-19 and 2021-

lawyer, associate professor of the Faculty of Medicine of the University of Latvia, Solvita Olsena. In the introduction of the program, a collection of stories of women's experiences are voiced. Alongside several hundred women's stories on obstetric violence were collected in programme's social media account.

210 Exhibition 'Being a parent. First year in portraits' with a public debate on obstetric violence - The public debaters were Minister of Health Daniels Pavļuts, home birth midwife Dina Ceple, gynaecologist Karlīna Elksne, associate professor of the Faculty of Medicine of the University of Latvia Signe Mežinska and clinical psychologist and cognitive-behavioural psychotherapist Marina Brice. During the debate women's stories of violence were read.

211 Sharing the experience of France dealing obstetric and gynaecological violence (project "MotherNet" (Horizon 2020 Twinnings, No. 952366), Lecturer - Loïc Bourdeau (Meinuth National University), https://www.institutfrancais-lituanie.com/archyvai/archyvai-konferencijos/akuserinis-ir-ginekologinis-smurtas-nuo-camille-laurens-iki-socialiniu-tinklu-dr-loico-bourdeau-paskaita/

212 Systemic violence in childbirth: A conversation following research, 2023.

213 Barriers in access to health care: Results of a survey of the experiences of women, girls and parents from Ukraine with temporary refuge with health care in Slovakia.

214 Respectful Care, *International Platform on Obstetric Violence*, https://respectfulcare.eu/

215 RODA, Peticija MOJ POROD – MOJE TIJELO – MOJ IZBOR, 2002, https://www.roda.hr/udruga/programi/trudnoca-i-porod/peticija-moj-porod-moje-tijelo-moj-izbor.html

216 Letter to Minister Varga on the occasion of the action Let's break the silence, STORK Roda, https://www.roda.hr/udruga/programi/trudnoca-i-porod/pismo-ministru-vargi-povodom-akcije-prekinimo-sutnju.html

22), and augmented by the case of Mirela Čavajda[217], coalitions formed more easily and earlier in the campaign[218].

In October 2018 during a parliamentary session, member of parliament Ivana Ninčević Lesandrić told her story of obstetric violence, being tied to a table and denied anaesthetic for a surgical miscarriage procedure, for which she was told not to speak of intimate things in the parliament and accused of lying[219]. Roda then took the opportunity to ask women to tell their own experiences of obstetric violence, which were sent to the Minister of Health[220]. These testimonies were read in public spaces throughout Croatia. To encourage political action, Roda demanded the adoption of an Action Plan for Women's Health 2019-2021[221] by the Prime Minister, with a multi-stakeholder working group, clear goals and funding allotments. However, no response was given to this request[222].

Despite resistance, the #BreakTheSilence (*#PrekinimoŠutnju*) campaign contributed to changes in public opinion towards greater condemnation of violence against women and increasing demands for the State to eradicate it.

4.2. Initiatives to collect women's voices have emerged on social media

Several initiatives to collect women's testimonies through social media have been identified across the Member States. The number and format of testimonies collected through those initiatives have led some researchers to describe this movement as an 'obstetrical '#MeToo'[223].

In **France**, in 2014, a midwife denounced on her blog the "husband's stitch". The testimony was relayed by the media and led to lively debates on the Internet and in the public press. Following this, a hashtag "PayeTonUtérus" (that could be loosely translated as *'that's what you have to pay for having a uterus'*)[224] was launched on Twitter, which brought together 7,000 testimonies in less than 24 hours. Another initiative followed ("I did not consent"), denouncing medical practices imposed on patients without prior information or consent. Several campaigns followed, including *'Balance ton gynéco'* ('report your

[217] The case involved the initial refusal of abortion by multiple hospitals under conscientious objection even though the foetus had a brain tumour that would have either led to death in the womb of severe diseases; despite the pregnancy conditions being in line with the Croatian legal provisions on abortion, the abortion was only allowed weeks later and the case received notable social attention (https://www.humanrightspulse.com/mastercontentblog/mass-conscientious-objection-is-making-abortion-inaccessible-in-croatia).

[218] Support for accessible, safe and legal termination of pregnancy in Croatia, Roda, https://www.roda.hr/en/news/support-for-accessible-safe-and-legal-termination-of-pregnancy-in-croatia.html

[219] Does our "male" society acknowledge the pain of a woman?, STORK Roda, https://www.roda.hr/udruga/dokumentacijski-centar/reakcije/priznaje-li-nase-%E2%80%9Cmusko%E2%80%9D-drustvo-bol-zene.html

[220] Letter to Minister Varga on the occasion of the action Let's break the silence, STORK Roda, https://www.roda.hr/udruga/programi/trudnoca-i-porod/pismo-ministru-vargi-povodom-akcije-prekinimo-sutnju.html

[221] RODA. 'Roda sends letter to Prime Minister about let's break silence', 2018, https://www.roda.hr/udruga/projekti/prekinimo-sutnju/roda-poslala-pismo-predsjedniku-vlade-republike-hrvatske.html

[222] RODA. 'Action plan for women's reproductive health', 2023, https://www.roda.hr/media/attachments/udruga/projekti/radar/Akcijski_plan_za_reproduktivno_zdravlje%20_zena.pdf

[223] Topçu S., Notre corps, leur « usine ». Obstétrique, (non) violence, féminisme, Institut d'études politiques de Paris, 2023.

[224] The hashtag is in reference to the notion that women face obstetric and gynaecological violence for the simple fact of having a uterus.

gyneco') or 'StopVOG' (VOG being the acronym for obstetric and gynaecological violence in French), both targeting obstetric and gynaecological violence. StopVOG reported in 2022 that they received more than 200 testimonies per month.

In 2020, a #WeToo debate over sexual and obstetric violence was launched in **Denmark**. In the public debate, Mødrehjælpen collected 1,400 narrative birth stories, including descriptions of coercion to interventions, abusive communication and no informed consent, to put pressure on politicians and legislators to rectify the crisis of obstetric violence[225].

In 2021, in **Estonia**, the campaign *'#mina ka sünnitajana'* has been considered as a 'Me Too' movement focused on obstetric violence. The campaign collected women's stories and carried out a survey to highlight the violation of women's rights during pregnancy and childbirth and also after childbirth[226].

In **Finland**, the campaign '#Minä Myös Synnyttäjänä ('Me Too in the birthing room/in childbirth) directly refers to the MeToo movement. It was initiated by birth activists in spring 2019 with the launch of a website and a Facebook page that invited people to share their experiences of being belittled, insulted, or abused and to be 'part of the change' by speaking out if they had experienced something similar. This campaign was the first to use the term 'obstetric violence' in public discussions[227].

In the **Netherlands**, in 2016, the Birth Movement initiated a campaign in which women were asked to share their negative experience with maternity care on social media. This campaign is also known as #rosesrevolution or #breakthesilence, previously initiated in several other countries. Due to the large number of women who shared their stories, the Dutch campaign attracted public and media attention[228].

In **Hungary**, the igyszultem.hu site collects the experiences of women who have given birth in a maternity institution in the last ten years, with particular regard to the quality of the maternity care experienced and the practice of paying gratuities[229].

In 2018, in **Slovenia**, #breakthesilence campaign collected around 150 stories of women who experienced obstetric violence, and those stories were reported in media[230].

In **Slovakia**, *'Svedectvá, Príbehy'* collects women's stories and experiences of childbirth and other related care[231].

The success of those initiatives in collecting thousands of testimonies attests of the widespread nature of these acts. Testimonies collected across Europe highlight the frequency, and above all, the banality of condescending, paternalistic, and discriminatory remarks (including insults and discriminatory comments) received by women during obstetric and gynaecological care, as well as the common prevalence of medical acts carried out without their prior consent or without respecting their choice[232]. They also point to a general failure of the healthcare system to take into account the specific nature of those acts, linked to their intimate and gendered nature. Stories shared by women also help to understand the various forms of this phenomenon, such as derogatory comments on women's

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225 Mødrehjælpen, 2021, *Uløst fødselskrise. Måske det er tid til at droppe prestige løsningerne.* "We have an unsolved birth crisis", https://moedrehjaelpen.dk/forside/nyheder/uloest-foedselskrise-maaske-det-er-tid-til-at-droppe-prestige-loesningerne/

226 MTÜ Emale, https://www.minakasynnitajana.ee/

227 https://minamyossynnyttajana.fi/, https://www.facebook.com/MinaMyosSynnyttajana/

228 Roses revolution The Netherlands https://www.facebook.com/groups/307827656082149/

229 Szülésélmény – térkép, https://igyszultem.hu/#/page/a-kutatasrol

230 Institut Umbilica, https://www.umbilica.si/

231 Ženské kruhy, https://zenskekruhy.sk/category/svedectva/

232 Simon, A. and Supiot. E. 'Les violences gynécologiques et obstétricales saisies par le droit'. Rapport n°19.18, 2023, https://linkinghub.elsevier.com/retrieve/pii/S1637408821001656

sexuality, insults, and harmful acts, but also more serious forms of violence, including sexual harassment, sexual assault and rape.

Interestingly, some of those initiatives have expanded beyond the frontiers of the Member States in which they had started, and transnational movements have emerged on obstetric and gynaecological violence across Europe. Common languages between some Member States or regions of Member States made it easier to 'export' those initiatives (e.g. the French campaign '*Balance ton gynéco*' on social media was followed up in Belgium and Luxembourg, and then used by CSOs to request action from the State in those countries too), while others have been replicated independently, such as the Roses Revolution, which started in **Spain** and then expanded to **Germany** followed by **Luxemburg, Lithuania, France, Czechia, Italy, Austria** and **Slovakia**. The Roses Revolution campaign invites people who experienced violence during childbirth to place a pink rose at the door of the healthcare institution where the violence took place, take pictures and post them on social media. In Germany, the Roses Revolution was the starting point of all public awareness campaigns on obstetric violence.

In **France**, the network StopVOG (Stop Obstetric and Gynaecological Violence) launched a petition on 7th March 2023 to include obstetric and gynaecological violence in the Istanbul Convention. The petition was translated in several languages and disseminated in several EU countries. To this day, the petition collected more than 175,000 signatures[233].

Additional examples of initiatives carried out to collect women's testimonies are presented in Annex 1.

4.3. Alternative spaces to support women in understanding and denouncing this violence

Given the limited societal understanding of this violence (and the lack of effective systems to report it, as discussed further in Section 6), alternative spaces, such as associations and observatories, have formed as spaces where women can obtain more information and sometimes get support to report this violence.

Some Member States (EL, ES, FR, IT, PT) have an Observatory on Obstetric Violence (OVO) and are members of InterOVO, the international network of observatories on obstetric violence, which links European Observatories with Latin American ones with the purpose of exchanging and disseminating information and data to decision-makers and the general public[234,235]. OVOs are civil society-led organisations that raise awareness on obstetric and gynaecological violence, increase knowledge about patients' rights and liaise with the competent authorities to tackle obstetric and gynaecological violence from a policy and legal point of view. OVO **Portugal** also features an anonymous place for healthcare providers to denounce this violence on their website[236].

In **Spain** in particular, among the alternative spaces for reporting, support groups and feminist women activists protect and care for women victims by offering safe spaces and the possibility of creating a support network. These spaces include *El parto es nuestro*, *PETRA Maternidades Feministas* or

[233] Change.org, *Ensemble, contre les violences obstétricales et gynécologiques!*, 2023, https://www.change.org/p/l-europe-doit-reconna%C3%AEtre-les-violences-obst%C3%A9tricales-et-gyn%C3%A9cologiques

[234] Quattrocchi P. (2019), *Obstetric Violence Observatory: Contributions of Argentina to the International Debate*, Medical Anthropology, 38:8, 762-776, DOI: 10.1080/01459740.2019.1609471

[235] https://www.elpartoesnuestro.es/blog/2016/03/08/8-de-marzo-declaracion-conjunta-de-los-observatorios-de-la-violencia-obstetrica

[236] OVO Portugal, Denúncias *Anónimas de Profissionais de Saúde*, https://ovoportugal.pt/denuncias/

associations such as *Dona Llum*. The social networks of these associations also serve to make some cases visible as women can expose their stories through these networks.

Two organisations in **Denmark** provide a space for women to share their stories and denounce this violence. *Mødrehjælpen* (Helping Mothers) is an organisation that offers support and counselling to pregnant women as well as families in vulnerable positions[237]. *Forældre og fødsel* (Parenthood and Childbirth)[238] is another NGO working on this issue by bringing cases of obstetric violence to public attention through the media and social media. Danish law requires 50,000 signatures in support of a suggestion in order to be raised in the Danish Parliament. *Forældre og Fødsel* raised such a suggestion demanding sufficient time and resources are set aside to provide care and support to those giving birth. Among sub-demands were the right to prenatal classes, individual care, continuous midwifery support, caseload midwifery, and different birth settings (homebirth, hospital and freestanding birth clinics). The suggestion reached over 50,000 votes and was subsequently raised in the Danish parliament where it was voted on, but negotiations on the concrete outcomes are still ongoing[239]. While this was placed highly on the agenda in 2022, the only concrete provision introduced so far has been the right of first-time mothers to stay two nights at the hospital following the birth.

In **Czechia**, some NGO's have addressed the topic of healthcare during childbirth and obstetric violence, for example, *UNIPA - Union of Midwives*[240], *Aperio*[241] and *Hnutí za aktivní mateřství* (Active Motherhood Movement)[242]. Women may seek information about this type of violence on their websites and find some support there. Other NGOs, such as *Liga lidských práv* (Human Rights League), deal with the issue of involuntary sterilisations, which mainly concerns Roma women.

A list of existing organisations providing support to women is available in Annex 1.

4.4. Initiatives emerging from healthcare professionals

A few examples have been identified where the campaigns and initiatives were driven by healthcare professionals themselves. Indeed, in some Member States, midwives have spearheaded certain initiatives to increase recognition and knowledge of the issues of obstetric and gynaecological violence, denouncing the unequal relationship between healthcare professionals and women patients (this has been documented in **Austria, France** and **Poland**[243]).

In **France**, the first cases reported by the media that contributed to drawing attention to obstetric and gynaecological violence were first reported by healthcare professionals, and notably medical students themselves, who publicly criticised the fact that they were not asked to request consent from women

237 Mødrehjælpen, https://moedrehjaelpen.dk/forside/about-moedrehjaelpen/

238 Forældre og Fødsel, Bedre Fødsler, https://www.fogf.dk/bedre-fodsler/

239 https://www.borgerforslag.dk/se-og-stoet-forslag/?Id=FT-06850

240 https://www.unipa.cz/

241 https://www.aperio.cz/en

242 https://www.iham.cz/

243 *Dans ma vie d'infirmière, Partage de témoignages et de connaissances autour du monde de la santé,* https://dansmaviedinfimiere.fr/podcast/sujet-de-sante-les-violences-gynecologiques-et-obstetricales/,%20http:/www.assembly.coe.int/LifeRay/EGA/Pdf/TextesProvisoires/2019/20190912-ObstetricalViolence-EN.pdf

patients[244]. A tweet from a pharmacist in 2015 revealed that routine vaginal examinations carried out by students on women who were under general anaesthesia (for reasons not related to gynaecological issues) and were not asked for their prior consent[245]. This event marked the start of a national debate in France, with the Health Minister promptly requesting an investigative report to be produced by the Medical Academy, which revealed that in 20 to 33% of cases, these examinations were carried out without obtaining prior consent from women[246].

In the **Netherlands**, the midwifery platform The Wise Voice (*Het Vroede geluid*) has a long read on obstetric violence and has published an informative video on the term[247]. The magazine Baby on the Way (*Baby op komst*) for pregnant women made by midwives has an entry on obstetric violence on its website[248] and the magazine for professional birth workers Early (*vakblad Vroeg*) also has an article on obstetric violence[249].

4.5. Impact of those initiatives on media

In some Member States, the media have been instrumental in relaying the existence of those initiatives, contributing to both fostering awareness of the issue and in bringing the issue to the forefront of the policy agenda.

Various media articles have been published in recent years[250] to provide a platform for women's experiences of obstetric and gynaecological violence. Importantly, these various forms of media help to disseminate these stories and contribute to the mainstreaming of the discourse condemning this violence.

In **Germany**, numerous reports, blogs, radio and television shows have been produced in response to the testimonies shared via the Roses Revolution[251]. However, these different forms of media showcase women's experiences of violence during childbirth and therefore do not cover the issue of gynaecological violence.

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244 Simon A., Supiot. E. *Les violences gynécologiques et obstétricales saisies par le droit*, Rapport n°19.18, 2023, https://www.sciencedirect.com/science/article/abs/pii/S1637408821001656?via%3Dihub

245 Ibid.

246 Rudigoz, R. C., Miliez, J., Ville, Y. and Crepin, G., *De la bientraitance en obstétrique. La réalité du fonctionnement des maternités, Bull. Acad. Natle Méd.*, Vol. 202, No 7, 2018, pp.1323-1340, https://www.academie-medecine.fr/wp-content/uploads/2018/09/P.1323-1340.pdf

247 Het vroede geluid, 2021, https://vimeo.com/546555320

248 Baby op komst, *Obstetrisch geweld*, https://babyopkomst.nl/news/obstetrisch-geweld/

249 Vroeg, *Omgaan met geweld tijdens de bevalling*, https://www.vakbladvroeg.nl/omgaan-met-geweld-tijdens-de-bevalling/

250 L'Obs - Actualités du jour en direct, *Il faut arrêter l'omerta' : "Paye ton gynéco" dénonce les violences obstétricales*, 2017, https://www.nouvelobs.com/rue89/rue89-nos-vies-connectees/20170801.OBS2842/il-faut-arreter-l-omerta-paye-ton-gyneco-denonce-les-violences-obstetricales.html; Le monde, *Derrière le « point du mari », le traumatisme de l'épisiotomie*, 2014https://www.isabelle-alonso.com/articles-1/le-point-du-mari-195; évènement Libération, *Contre les violences gynécologiques, la lutte prend corps*, 2017, https://www.liberation.fr/france/2017/08/15/contre-les-violences-gynecologiques-la-lutte-prend-corps_1590109/; Le Figaro Santé, *Quand l'accouchement se vit dans la violence*, 2017, https://sante.lefigaro.fr/article/quand-l-accouchement-se-vit-dans-la-violence; Franceinfo, *Césariennes à vif, épisiotomies imposées… Le grand tabou des violences durant l'accouchement*, 2016, https://www.francetvinfo.fr/sante/cesariennes-a-vif-episiotomies-imposees-le-grand-tabou-des-violences-durant-l-accouchement_1881273.html

251 Gerechte Geburt, *Berichte über die Roses Revolution*, https://www.gerechte-geburt.de/home/roses-revolution/wer-berichtet/

Similarly, in **Lithuania**, articles and blog posts have been produced to bring attention to obstetric violence and to discuss and share experiences, some of which stemmed from the Roses Revolution[252]. One blog post shared by Laima Vakrinaite discusses cases during labour where unnecessary medical procedures are performed on women's bodies that violate their dignity and rights[253]. Among some of the reasons she identifies for this violence, the vulnerability of women, the power of doctors and the impunity they face were highlighted.

The term obstetric racism, or 'racism in maternity care', an important counterpart of obstetric violence, has appeared in several media in the **Netherlands**. In the renowned journal Free Netherlands (*Vrij Nederland*), and the Dutch public radio Channel 1, interviews with midwife Bahareh Goodarzi were recently published on obstetric racism and structural inequality in Dutch maternity care[254]. Bahareh Goodarzi's academic research also contributes to greater awareness of inequity in Dutch maternity care, both professionally and publicly[255]. Midwife Pia Qreb shared her experiences on the acclaimed feminist podcast platform Sauce (*Dipsaus*) and in the journal Lovel[256] [257].

In **Slovakia**, the documentary film by Zuzana Límová titled *Mezi nami* (Between Us) was produced in 2016 on obstetric violence in Slovak maternity hospitals[258]. In addition, the book *Nahlas* published by the NGO Ženské Kruhy in 2020 brings together 20 stories in which women point out the shortcomings and failures of the healthcare system[259].

In **France**, the comics *L'histoire de ma copine Cécile* was published online by the feminist cartoonist Emma in June 2016[260], followed by *Tu enfanteras dans le bonheur*, another comic published by Fiamma Luzzati in January 2019[261]. Juliette Boutant and Thomas Mathieu devoted a chapter of Crocodiles to obstetric and gynaecological violence in 2019[262]. These comic strips were based on testimonies and placed the characters in the situation of an obstetric examination or childbirth in hospital.

Other forms of media include documentaries such as *Accoucher dans la violence*, a documentary detailing the story of Charlotte Bienaime who recounts her story of undergoing a uterine revision

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252 Alfa, *Lietuvių „Rožių revoliucija" – prieš akušerinį smurtą*, 2015, https://www.alfa.lt/straipsnis/49920561/lietuviu-roziu-revoliucija-pries-akuserini-smurta/

253 Vilniaus Moterų namai, *Žmogaus teisių pažeidimai ir smurtas akušerijoje*, https://www.vmotnam.lt/metodine-informacija/zmogaus-teisiu-pazeidimai-ir-smurtas-akuserijoje/

254 Vrij nederland, Waarom geboortezorg niet voor iedereen gelijk is: 'Alles, alles, alles is wit', https://www.vn.nl/zwangerschap-videocolumn-goodarzi/

255 Medish Contact, *'Ras' en etniciteit registreren in de zorg: een precaire kwestie*, 2022, https://www.medischcontact.nl/actueel/laatste-nieuws/artikel/ras-en-etniciteit-registreren-in-de-zorg-een-precaire-kwestie

256 Dipsaus, *Institutioneel racisme in de geboortezorg*, 2020, https://www.dipsaus.org/exclusives-posts/2020/7/18/institutioneel-racisme-in-de-geboortezorg

257 Tijdschrift L., *Inequity In Dutch Healthcare: A Series*, 2022, https://tijdschriftlover.nl/english/inequity_in_dutch_healthcare_a_series, https://tijdschriftlover.nl/english/inequity_in_maternity_care, https://tijdschriftlover.nl/english/inequity_in_preventive_care

258 Česko-Slovenská filmová databáze, *Medzi nami*, 2016, https://www.csfd.cz/film/523707-medzi-nami/prehled/

259 Ženské kruhy, *nahlas*, https://zenskekruhy.sk/produkt/kniha-nahlas/

260 Clit E., *L'histoire de ma copine Cécile*, 2016, https://emmaclit.com/2016/06/10/lhistoire-de-ma-copine-cecile/

261 Le monde, *Tu enfanteras dans le bonheur*, 2019, https://www.lemonde.fr/blog/lavventura/2019/01/24/tu-enfanteras-dans-le-bonheur/

262 Boutant, J., Mathieu, T., *Les crocodiles sont toujours là*, Paris: Casterman, 2019.

without anaesthesia. Later, the first long French-speaking investigative documentary on obstetric violence, *Tu Enfanteras dans la Douleur* was directed by Ovidie from 2017 and broadcasted in July 2019 by Arte[263]. Ovidie collects voices of the victims as well as those of midwives, gynaecologists, activists and experts to analyse the situation of obstetric and gynaecological violence and explore its systemic roots. This was followed by three fictional short films that were produced by Nils Tavernier from the series *Et si on s'écoutait?* (2020), which were carried out in collaboration with La maison des femmes and Cercle d'Etudes des Gynécologues Obstétriciens de Île de France[264] (see Section 7.2.3). Also, the documentary *Ecartez les jambes: enquête sur les violences gynécologiques*, broadcasted in May 2023, chronicles women testifying to the trauma of their childbirth[265].

[263] Java Films, *You will give birth in pain*, 2019, https://javafilms.fr/film/you-will-give-birth-in-pain/

[264] Salles C., Le rôle des représentations visuelles et audiovisuelles dans la reconnaissance de la notion de « violences obstétricales » en France et en Belgique, Santé Publique, Vol. 33, No. 5, 2021, pp. 655-662, https://www.cairn.info/revue-sante-publique-2021-5-page-655.htm

[265] Télérama, *Violences gynécologiques : "Il faut réfléchir à une autre prise en charge, validée par les femmes"*, 2023, https://www.telerama.fr/television/violences-gynecologiques-il-faut-reflechir-a-une-autre-prise-en-charge-validee-par-les-femmes-7016204.php

5. LEGAL AND POLICY RESPONSES TO OBSTETRIC AND GYNAECOLOGICAL VIOLENCE

Key findings

No Member state has adopted distinct provisions against obstetric and gynaecological violence, but all Member states have legislative provisions on patients' rights, non-discrimination, gender-based violence/violence against women, that could apply to gynaecological and obstetric violence.

However, as this form of violence is not recognised as a violation of women's rights, those provisions are hardly invoked in practice at national level.

Obstetric and gynaecological violence is gaining political traction in many Member States, mostly in response to awareness raising campaigns and initiatives to collect women's testimonies. The issue is increasingly being addressed at legislative and policy level across the EU Member States.

5.1. Applicable legal framework to obstetric and gynaecological violence in EU Member States

In **no EU Member State has obstetric and gynaecological violence been recognised by national law, whether as a violation of women's sexual and reproductive health rights or another specific form of gender-based violence**[266]. This means that, in order to seek redress, as explained in the next section (Section 6), victims must rely on pre-existing legal actions, available under civil or criminal law or via extra-judicial avenues. However, although no distinct provisions against obstetric or gynaecological violence exist in any of the EU legal systems, all Member states have **legislative provisions and/or constitutional norms and principles on patient rights** (e.g. the need for fully informed consent for medical treatment, the principle of refusal of treatment by both the patient and the physician, the right to speak against unfair treatment, etc.), **non-discrimination** (based on gender, race, age, sexual orientation, disability, ethnic and social origin, religion or belief, genetic features, etc.) **and gender-based violence** with regards to physical violence, verbal violence, psychological violence and sexual violence, aiming at ensuring, inter alia, safety, respect, non-discrimination, confidentiality, privacy, informed consent and taking into account intersectionality issues.

Furthermore, different degrees and forms of physical violence are covered by **criminal law** with slight differences from one Member State to another: for example, abdominal expression could be considered as a criminal offence of negligent physical injury, while a health professional who performs a c-section or sutures the perineum after an episiotomy without anaesthetic could even be considered guilty of torture, and episiotomies performed without medical reason or procedures such as the "husband's stitch" could even be considered to be female genital mutilation. More generally, it should be noted that, in principle, attacks on physical integrity constitute criminal offences at different degrees, whether intentional or not, including when perpetrated in the healthcare sector. However, they do not constitute offences if the perpetrator can invoke an objective justification, in particular an authorisation or an order from the law. As a result, most medical interventions carried out on patients

[266] At regional level, two Spanish communities have provisions defining obstetric violence in different legislations, e.g., within the law on sexist violence in Catalonia. However, being adopted at regional level, those provisions have no legal consequences. See Section 3.4.2.

are punishable under criminal law when the legal framework is not respected: for example, in the event of a breach of the patients' rights legislation. Other criminal provisions help to provide a framework for the activities of healthcare professionals, particularly when there is no harm to the physical integrity of patients. We might mention, for example, in **Belgium,** the law of 22 May 2014 designed to combat sexism in the public space[267], which could justify prosecution and conviction for, among other things, certain inappropriate comments or behaviour directed at women patients[268].

All those provisions and principles, whether from the legislations on patients' rights, non-discrimination, gender-based violence or the criminal code, apply on paper to gynaecological and obstetric violence. However, as this form of violence is not recognised as a violation of women's rights, those provisions are hardly invoked in practice at the national level.

A legal recognition of obstetric and gynaecological violence as a violation of women's human rights is essential to protect, prevent and prosecute this form of gender-based violence according to the United Nations Special Rapporteur on Violence Against Women, who, in a report on obstetric violence and mistreatment, highlights that '*States have an obligation to respect, protect and fulfil women's human rights, including the right to [the] 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*'[269].

Although national laws regulating patients' rights or minimum standards of healthcare recognise a series of rights that are of the utmost importance in obstetric and gynaecological care, they mostly refer to medical interventions or treatments in general, without targeting the specificities of gynaecological and obstetric care.

This is the case, for example, in **Belgium**, where the legislation on patients' rights recognises the right to quality services that meet their needs, the right to information about their state of health and how it is evolving, free and informed consent to any intervention, the protection of patients' privacy and respect for their intimacy, and the right to the "*most appropriate*" care for pain[270]. Furthermore, the law on the quality of healthcare practice[271] requires healthcare professionals to "*know precisely the limits of their competences*". In particular, they must ensure that they have the necessary supervision to provide healthcare "*at a high level of quality*". When they provide high-risk services, they are obliged to provide

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267 Law of 22 May 2014 designed to combat sexism in the public space, modifying Law of 10 May 2007 designed to combat discrimination against women and men to criminalise the discrimination act (*Loi tendant à lutter contre le sexisme dans l'espace public et modifiant la loi du 10 mai 2007 tendant à lutter contre la discrimination entre les femmes et les hommes afin de pénaliser l'acte de discrimination*), available at: https://etaamb.openjustice.be/fr/loi-du-22-mai-2014_n2014000586

268 Thuysbaert,A.I., Hausman J.M., Vers l'émergence de la problématique des " violences obstétricales et gynécologiques " dans la sphère politique et institutionnelle belge ?, Journal de droit de la santé et de l'assurance maladie, Vol. 37, 2023, p. 68. https://hal.science/hal-04198796/document

269 Simonvic D., 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, UN Human Rights Council, 2019. https://digitallibrary.un.org/record/3823698?v=pdf

270 Law of 22 August 2002 on patients' rights (*Loi du 22 août 2002 relative aux droits du patient*), https://etaamb.openjustice.be/fr/loi-du-22-aout-2002_n2002022737.html

271 Law of 22 April 2019 on the quality of healthcare practice (*Loi du 22 avril 2019 relative à la qualité de la pratique des soins de santé*), https://etaamb.openjustice.be/fr/loi-du-22-avril-2019_n2019041141.html

both an effective emergency procedure in the event of complications and a second procedure for transferring patients. This is particularly relevant for midwifery birthing centres[272].

Other countries have specific legislation on consent. In **Italy**, Law n. 219/2017 on consent […][273] "*identifies informed consent as an essential part of the "relationship of care and trust between patient and doctor*" for any medical treatment. It is interesting to note that this law, which mainly focuses on terminally ill individuals (although the provisions on informed consent are considered applicable to any medical intervention), refers to the right to informed consent 'in every phase of the patient's *illness'*.

In **France**, the Kouchner Act of 2002[274] is based on the principle of patient autonomy and on a more balanced power relationship between patients and healthcare professionals. The law aimed at reaffirming doctor's obligation to obtain and respect the patients' consent and their right to fair information. It states that free and informed consent must be obtained for any medical act by healthcare professionals, and this consent can be withdrawn at any time. However, in the field of obstetrics and gynaecology, this principle is often difficult to apply: there is no consensus on the conditions for obtaining consent; and consent is often taken for granted as soon as the woman enters the consulting or delivery room[275].

Few Member States, on the other hand, expressly include obstetric and gynaecological treatments in patients' rights legislation. This is the case for instance in **Portugal**, where Law no. 15/2014[276] consolidates the rights and duties of the users of the health services, which contemplates some rights in pregnancy, childbirth and postpartum in a section entitled '*protection regime in preconception, medically assisted procreation, pregnancy, childbirth, birth and the postpartum period*''. This law was amended by Law no. 110/2019, which added rules regarding pregnancy, childbirth and postpartum[277]. According to this law, every woman has the right to, inter alia: privacy and confidentiality, continuous assistance, decent and respectful treatment (free from coercion, violence and discrimination, and the right to a humanized birth), an interpreter (if necessary), informed consent, the best quality of healthcare, breastfeeding support, pain relief, minimal interference, as well as access to healthcare, justice and accountability mechanisms.

In **Ireland**, the Code of Professional Conduct and Ethics for registered nurses and registered midwifes[278] states the responsibilities, among others, '*to make every valid or reasonable effort to protect the life and*

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[272] Thuysbaert A.I., Hausman J.M., Vers l'émergence de la problématique des 'violences obstétricales et gynécologiques' dans la sphère politique et institutionnelle belge?, Journal de droit de la santé et de l'assurance maladie, Vol. 37, 2023, pp.62-74. https://hal.science/hal-04198796/document

[273] Law n. 219/2017 Provisions for informed consent and advance directives (*Legge n. 219/2017 Norme in materia di consenso informato e di disposizioni anticipate di trattamento*), https://www.gazzettaufficiale.it/eli/id/2018/1/16/18G00006/sg

[274] Law 2002-303 of March 4, 2002 relating to patients' rights and the quality of the health system (*Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé*), https://www.legifrance.gouv.fr/loda/id/JORFTEXT000000227015

[275] Simon A., Supiot, *Les violences gynécologiques et obstétricales saisies par le droit*", Rapport n°19.18, 2023. https://linkinghub.elsevier.com/retrieve/pii/S1637408821001656.

[276] Law no. 15/2014, of March 21 (Lei n. 15/2014, de 21 de março), https://diariodarepublica.pt/dr/detalhe/lei/15-2014-571943

[277] Law 110/2019, of 9 September (*Lei n.º 110/2019 de 9 de setembro*) https://www.iasaude.pt/attachments/article/6320/lei_110_2019_procriacao_medicamente_assistida.pdf.

[278] Code of Professional Conduct and Ethics "Respect for the dignity of the person". The Nurses and Midwives Act 2011 regulates professional misconduct, poor professional performance and non-compliance with that code of professional misconduct. https://www.nmbi.ie/Standards-Guidance/Code.

health of pregnant women and their unborn babies', to '*strive to communicate with patients about their care and give them information in a manner they can understand*' and for '*seeking the patient's consent to nursing and midwifery treatment and care*'.

In **Romania**, the law on patient's rights[279] that contains provisions on informed consent also affirms the principle of non-discrimination based on sex in accessing health services and medical treatment and, in particular, the right to a well-informed, healthy, and free decision about the patient's sexual and reproductive life.

In **Spain**, the Law for the effective equality of women and men[280] does address discrimination on the grounds of pregnancy or maternity, providing legal consequences of discriminatory conduct through a system of reparations or compensation. Organic Law 1/2023, of 28 February, which modifies Organic Law 2/2010, of 3 March, on sexual and reproductive health and the voluntary interruption of pregnancy[281], contemplated the possibility of including obstetric violence in its definition, but as explained in Section 7, the concept was finally left out of the law and replaced by "Appropriate gynaecological and obstetric interventions" and "Violence against women in the reproductive field". Furthermore, at regional level, several interesting developments have taken place , with the recent inclusion of 'obstetric violence' in the legislation of some Autonomous Communities (regions): the Autonomous Community of **Catalonia** incorporated "*obstetric violence and violation of sexual and reproductive rights*" as a type of 'male violence' in its legislation[282], being the pioneer community in doing so; the Basque autonomous community also specifies in its law for the equality of women and men that these issues constitute 'male violence'.

While both the Catalan and the Basque autonomous communities have framed obstetric violence under violence against women, the Community of Valencia has incorporated the concept of obstetric violence in its Health Law[283], recognising rights in the area of sexual and reproductive health of women to guarantee measures to combat obstetric violence, as defined by the World Health Organisation (WHO). The box below briefly summarises the developments in two of those Autonomous Communities (Catalonia and Valencia) to identify differences and commonalities[284].

Other recent developments have also taken place in other Autonomous Communities in Spain. In December 2022, the Plenary of the Regional Chamber of the Canary Islands Government approved a Proposition of law for the regulation of obstetric violence[285].

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279 Law 46/2003, of 21 January 2003 (*Lege Nr. 46/2003 din 21 ianuarie 2003*), http://cas.cnas.ro/media/pageFiles/Legea%2046-2003%20actualizata.pdf

280 Organic Law 3/2007, of 22 March, for the effective equality of women and men (*Ley Orgánica 3/2007, de 22 de marzo, para la igualdad efectiva de mujeres y hombres*), https://www.boe.es/buscar/act.php?id=BOE-A-2007-6115

281 Organic Law 1/2023 of 28 February 2023 (Ley Orgánica 1/2023, de 28 de febrero, por la que se modifica la Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo), https://www.boe.es/buscar/doc.php?id=BOE-A-2023-5364

282 Law 17/2020, of 22 December (*Ley 17/2020, de 22 de diciembre, de modificación de la Ley 5/2008, del derecho de las mujeres a erradicar la violencia machista*), https://www.boe.es/buscar/doc.php?id=BOE-A-2021-464

283 Law 10/2014, of 29 December (*Ley 10/2014, de 29 de diciembre, de Salud de la Comunitat Valenciana*), https://www.boe.es/buscar/pdf/2015/BOE-A-2015-1239-consolidado.pdf

284 Additional information is provided in the Case studies presented in Annex 1.

285 10L/PNLP-0550 Del GP Socialista Canario, contra la violencia obstétrica a la mujer, https://www.parcan.es/files/pub/bop/10l/2022/520/bo520.pdf

Box 3: Framing obstetric and gynaecological violence under violence against women: The example of Catalonia

In 2020, the Catalan Parliament amended the Catalan law against gender-based violence[286] (Law 17/2020, of 22 December, amending Law 5/2008, on the right of women to eradicate gender-based violence) to expand the scope and forms of violence legally recognised, as well as potential victims (the law now including girls and transgender women).

The 2020 legislative amendment, promoted by an alliance of left-wing parties and feminist groups, was initially aimed at including institutional violence and digital violence, and to update the law in accordance with the Istanbul Convention. However, during the hearings, feminist associations and academics called on the need to broaden the focus of the reform to include other forms of gender-based violence, including obstetric violence. Such suggestions were supported by the members of the Equality Commission, and the Parliament approved the section of Law 17/2020 that pertained to obstetric violence and violation of sexual and reproductive rights with a large majority of 130 votes in favour, five against, and no abstentions[287], recognising obstetric violence and the violation of sexual and reproductive rights as forms of violence against women.

The 2020 law also recognised that in addition to intimate relationships, at home, and at the workplace, women can also experience violence in educational settings, political and public spaces (including digital spaces), as well as in institutional spaces.

The 2020 legislative amendment (Article 4.d) defines obstetric violence and violation of sexual and reproductive rights as follows:

"*This consists of preventing or hindering access to reliable information which is necessary for independent and informed decision-making. It can have an impact on various areas of physical and mental health, including sexual and reproductive health, and can prevent or hinder women from making decisions about their sexual practices and preferences and about their reproduction and the conditions under which it takes place according to the situations included in the applicable sectoral legislation. It includes forced sterilisation, forced pregnancy, impeding abortion in the legally established cases, hindering access to contraceptive methods, methods for the prevention of sexually transmitted diseases and HIV and to assisted reproduction methods and also gynaecological and obstetric practices which do not respect women's decisions, bodies, health and emotional processes*".

This definition emphasises the issue with the lack of informed consent, which is understood as the obstacle or difficulty in accessing adequate and accurate information necessary for making independent and well-informed choices related to matters impacting sexual and reproductive health. The violation of sexual and reproductive rights, as practices that can be carried out by public employees, would constitute an expression of institutional violence, an area that Law 17/2020 covers with the following definition (article 5.6):

[286] Law 17/2020, of 22 December, amending Law 5/2008, on the right of women to eradicate gender-based violence (*Ley 17/2020, de 22 de diciembre, de modificación de la Ley 5/2008, del derecho de las mujeres a erradicar la violencia machista*), https://www.boe.es/buscar/doc.php?id=BOE-A-2021-464

[287] However, in April 2021, the Parliamentary Group of the Popular Party in the Congress of Deputies filed an appeal of unconstitutionality against several articles of the law. The text discusses the proposed changes to the law, including the inclusion of girls and transgender women, the definition of sexual consent (similar to the one in Organic Law 10/2022), the expansion of forms of violence (including obstetric violence), and the establishment of protocols for action against sexual harassment and other forms of sexist violence by political parties. The Constitutional Court admitted this appeal for processing, but it has not yet been resolved.

"*Actions and omissions of the authorities, public personnel and representatives of any public body or institution whose purpose is to delay, hinder or prevent access to public policies and the exercise of the rights recognised by this Act to ensure a life free of sexist violence in accordance with the situations included in applicable sectoral legislation. Any lack of quantitative and qualitative due diligence in tackling sexist violence constitutes a manifestation of institutional violence if it is known about or promoted by the authorities or becomes a pattern of repeated and structural discrimination. This violence can stem from a single serious act or practice, from the repetition of acts or practices of lesser scope that generate a cumulative effect, from the failure to act when there is awareness of the existence of a real or imminent danger, and from re-victimising practices or omissions. Institutional violence includes law-making and the interpretation and application of law intended to bring about or resulting in the same outcome. The use of parental alienation syndrome is also institutional violence*".

The law has introduced a precise definition of due diligence (Article 3.h): "*the obligation of the public authorities to adopt legislative and other measures so as to take action with the requisite speed and efficiency and ensure that authorities, staff, officials, public entities and other actors working on behalf of these public authorities comply with this obligation in order to appropriately prevent, investigate, prosecute, punish and redress acts of sexist violence and protect the victims*".

The Catalan legislative framework is a pioneer in Europe due to its incorporation of obstetric violence and the violation of sexual and reproductive rights, going even beyond the Istanbul Convention framework.

Box 4: Framing obstetric and gynaecological violence under health: the example of the Comunitat Valenciana

The Comunitat Valenciana has also incorporated the concept of obstetric violence into its legislation but has done so under the framework of health law[288]. In line with the World Health Organisation (WHO), the legislation aims at guaranteeing measures to combat obstetric violence, linking them to the area of the sexual and reproductive health of women.

In 2021, a non-legislative proposal was approved by the Valencian Parliament in the ordinary plenary session, but met some oppositions from more conservative parties and some sectors of the medical communities[289].

Taking into account the concern of healthcare professionals about the possibility that the legal assimilation of obstetric violence with gender-based violence could imply the criminalisation of professionals under the rules foreseen for intentional situations, the legislative chamber of the Valencian Community adopted a different legal classification. This inclusion, unlike what was previously done in Catalonia, took place through the approval of Law 7/2021, of 29 December, of the Generalitat[290] on fiscal, administrative and financial management and organisational measures of the Generalitat 2022, which amended Law 10/2014, of 29 December, of the Generalitat, on Health of the Valencian Community. Part of the rationale behind such decision was that obstetric violence could not only be restricted to legislation on violence against women, but should be transversally addressed, especially due to the consequences it has on women's health.

[288] Law 10/2014, of 29 December *(Ley 10/2014, de 29 de diciembre, de Salud de la Comunitat Valenciana*), https://www.boe.es/buscar/pdf/2015/BOE-A-2015-1239-consolidado.pdf

[289] *Controversia política y sanitaria en la Comunitat Valenciana, ¿cómo se penaliza la violencia obstétrica?*, La Razón., 24.11.2021, https://www.larazon.es/comunidad-valenciana/20211124/6x47ke6fwvbfza6qtqoextyxxy.html

[290] Law 7/2021, of 29 December (*Ley 7/2021, de 29 de diciembre, de la Generalitat, de medidas fiscales, de gestión administrativa y financiera y de organización de la Generalitat*), 2022 (2021/13105). DOCV 9246.

Law 7/2021 of 29 December (Law of measures) in its Chapter II, Section 3, Article 74 included the following wording:

"Law 10/2014 on Health of the Valencian Community is amended, specifically a paragraph is added to Article 59 bis, paragraph 1, and a new letter b is created, reordering the following letters, with the following text: b) to guarantee measures tending to combat obstetric violence defined according to the World Health Organisation"[291]

In **Lithuania**, to respond to patients' preferences and to ensure people's right to choose health care services, the Ministry of Health enforced the Procedure of Caesarean Section Surgery at the Request of a Pregnant Woman (2022)[292] and the Procedure of Childbirth at Home Services (2019)[293].

Finally, one Member State has adopted specific **legislation on perinatal care**: the standard of perinatal care, set up by the Regulation of the Minister of Health of 16.08.2018 on the organisational standard of perinatal care, has been in force in **Poland** since January 2019. It primarily sets out guidelines for the organisation of care that should be provided to a woman in the hospital during pregnancy, physiological labour, the postpartum period and during her care of the newborn, but it does not appear there. The standard obliges medical personnel to respect the right to informed participation in decisions related to pregnancy, labour, puerperium and the care of the newborn, including the scope of actions taken and medical procedures used; to treat the woman with respect; respect the privacy of the parturient and her sense of intimacy; and to always obtain the consent of the parturient or her legal representative for the performance of procedures and examinations. However, there is no enforcement in place. This, in addition to the fact that there is a lack of awareness of this type of violence, not only among healthcare professionals, but among victims too (and legal professionals), limits the application of these principles and renders the applicable legal framework less effective.

Some Member States have developed legislation targeting some forms of obstetric and gynaecological violence that have historically affected **specific groups of women, such as Roma women.**

- In **Czechia**, the 2022 law on the provision of a one-time sum of money to persons sterilised in violation of the law entered into force[294] .
- In **Slovakia**, the law on 'one-time financial compensation for women sterilised in violation of the law' is currently in the legislative process, in the comment procedure[295]. The law limits the time scope for compensation for the victims who were involuntarily sterilised between 1966 and 2004 only. Victims should be paid a lump sum of €5,000. Both these limitations have received criticism from women's organisations and Ombudsperson[296].

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[291] Original text: "Se modifica la Ley 10/2014 de Salud de la Comunidad Valenciana, en concreto se añade un párrafo al artículo 59 bis, apartado 1, y se crea una nueva letra b, reordenando las siguientes letras, con el siguiente texto: b) a garantizar las medidas proclives a combatir la violencia obstétrica definida según la Organización Mundial de la Salud."

[292] Procedure of Caesarean Section Surgery at the Request of a Pregnant Woman (2022). TAR, No. 21812. https://eseimas.lrs.lt/portal/legalAct/lt/TAD/6ad74a36562b11edba0ded10be2fa21c?positionInSearchResults=0&searchModelUUID=4794d697-c36d-4728-9c6d-b81710237853

[293] Procedure of Childbirth at Home Services (2019). TAR, No. 190. https://eseimas.lrs.lt/portal/legalAct/lt/TAD/a3e200d1102611e9b79ed4f43836384a?positionInSearchResults=0&searchModelUUID=4794d697-c36d-4728-9c6d-b81710237853

[294] Law 297/2021 (*Zákon č. 297/2021 Sb.*Zákon o poskytnutí jednorázové peněžní částky *osobám sterilizovaným v rozporu s právem a o změně některých souvisejících zákonů*), https://www.zakonyprolidi.cz/cs/2021-297

[295] Law 64/2023 (LP/2023/64 Legislatívny zámer zákona o jednorazovom finančnom odškodnení žien sterilizovaných v rozpore s právom), https://www.slov-lex.sk/legislativne-procesy/-/SK/LP/2023/64

[296] 2022 Ombudsman Report (*VEREJNÝ OCHRANCA PRÁV, Správa o činnosti verejného ochrancu práv za rok, 2022*), https://vop.gov.sk/wp-content/uploads/2023/04/Sprava_2022_final2.pdf

5.2. Towards a better recognition at Member State level

Overall analysis shows that obstetric and gynaecological violence is gaining political traction in many Member States, mostly in response to awareness raising campaigns and initiatives to collect women's testimonies. Public institutions have addressed the issue in several Member States through a range of initiatives.

5.2.1. Legislative proposals to legally frame the issue

In a number of Member States, legislative proposals have been put forwards to push for better legal recognition of the issues.

In **Croatia**, the government made a number of promises after the first wave of the #PrekinimoŠutnju campaign in 2014 and later in 2018, however, the majority of these promises have not come to fruition.

In **France**, after recent highly publicised cases of obstetric and gynaecological violence[297], two bills have been drafted to combat this phenomenon in 2023. Using different terminologies to frame the issue ('violence' and 'well-treatment[298]'), they propose distinct approaches with regards to the potential criminal classification of such acts: one seeks to create a specific offence in the Penal Code (proposal law no. 982 *aiming to recognise and punish obstetric and gynaecological violence and to combat this violence against women*[299]), the other wishes to strengthen the already existing articles of law without creating a new offence (Proposal for law no. 238 *aimed at strengthening caring gynaecological and obstetrical follow-up*[300]). These laws are still in discussion.

Examples of attempts made to change the legal framework have also been identified in **Portugal**, **Lithuania**, **Italy** and **Luxembourg**.

[297] https://www.liberation.fr/societe/droits-des-femmes/la-lutte-contre-les-violences-obstetricales-et-gynecologiques-sorganise-20240410_ICS5WWX36JFMRPXIEHRULSMVOE/

[298] *Bientraitance* in French.

[299] Draft Law no. 982 aiming to recognize and punish obstetric and gynaecological violence and to combat this violence against women (*Proposition de loi no 982 visant à reconnaître et sanctionner les violences obstétricales et gynécologiques et à lutter contre ces violences faites aux femmes*), Assemblée nationale, 16e lég, 21 mars 2023, https://www.assemblee-nationale.fr/dyn/16/textes/l16b0982_proposition-loi

[300] Draft Law no. 238 aimed at strengthening caring gynaecological and obstetrical follow-up (*Proposition de loi no 238 visant à renforcer un suivi gynécologique et obstétrical bientraitant*), Sénat, 12 janvier 2023, https://www.senat.fr/leg/ppl22-238.html

Box 5: Proposals to change the Portuguese legal framework

In Portugal, a Resolution of the Parliament was issued in 2021 recommending the government to take measures to eliminate obstetric violence and conduct a study on obstetric violence[301]. This was followed by a proposal of law to strengthen the protection of women in pregnancy and birth through the criminalization of obstetric violence[302], which was not adopted.

It proposed amendments to Law 110/2019 to better define obstetric violence:

"4 - Obstetric violence is considered to be any conduct directed at women, during labor, birth or the postpartum period, carried out without their consent, which, constituting an act of physical or psychological violence, causes pain, damage or unnecessary suffering or limits their power of choice and decision.
5 - For the purposes of the provisions of the previous paragraph, the following are understood as:
a) Physical violence, the use of force or physical restrictions, namely the performance of the Kristeller maneuver, physical attacks, restrictions on freedom of movement imposed on the parturient woman, forced fasting, the use of pharmacological means without authorization, the induction of labor, the administration of oxytocin and the intentional or negligent denial of pain relief to the woman in labour;
b) Psychological violence, the use of inappropriate, rude and, threatening language to the woman's self-esteem, including situations of discriminatory treatment, disregard of the parturient woman's requests and preferences, omission of information about the course of the birth and the procedures adopted and the prohibition of the accompanying person to stay.
6 - *The use of episiotomy in cases where there is no medical justification for its practice constitutes the crime of female genital mutilation, foreseen and punished under the terms of article 144 º of the Penal Code."*

Amendment to the article 144 of the Penal Code on female genital mutilation was also foreseen, stating:

"Article 144.º-A[...]1 - [...].2 - [...].3 - *Interventions carried out by a doctor or other legally authorized person that result in the genital mutilation of a female person, in violation of the leges artis and thus creating a danger to life or a danger of serious harm to the body or to health, are punished with a prison sentence of up to 2 years or a fine of up to 240 days, if a more serious penalty is not applicable to them due to another legal provision."* According to such definition, episiotomy without clinical indication should be considered female genital mutilation.

The proposal also wanted to add the article 166. º-A in the Penal Code, focussing on obstetric violence:

"Article 166º. º-A

Obstetric Violence
1 - Anyone who subjects a woman, during labor, childbirth or the postpartum period, to physical or psychological violence, which causes her pain, damage or unnecessary suffering or limits her power of choice and decision-making , is punished with a prison sentence of up to 1 year or a fine.
2 - Criminal proceedings depend on a complaint.
3 - The penalty is increased by one third, in its minimum and maximum limits, if the crime is committed:
a) In the presence of stillbirth or termination of pregnancy;
b) Against people at the extremes of reproductive age;
c) Against mother, unborn child or child with disabilities;

[301] Parliamentary assembly of the Republic, Resolution no. 181/2021 (*Resolução da Assembleia da República n.º 181/2021, de 28 de junho*), https://diariodarepublica.pt/dr/detalhe/resolucao-assembleia-republica/181-2021-165865615

[302] Draft Law n. 912/2021 (Projeto De Lei N.º 912/Xiv/2.ª reforça A Proteção Das Mulheres Na Gravidez E Parto Através Da Criminalização Da Violência Obstétrica), https://debates.parlamento.pt/catalogo/r3/dar/s2a/14/02/167/2021-07-14/2?pgs=2-11&org=PLC

d) Against victims of domestic violence, sexual abuse, harmful practices or human trafficking;
e) Against people living in extreme poverty, particularly those with income below the poverty line or low levels of literacy;
f) Against migrants and refugees."

Some researchers have pointed out the impact of COVID-19 in revealing the issues with regards to obstetric care in Portugal, and in fostering initiatives to see some changes in how the issue is legally framed.

In 2023, there were two new laws proposals and one resolution proposal submitted at the same time to the parliament by the parliamentary group "Bloco de Esquerda". However, due to the fall of the government a few days later, these proposals were not discussed (nor was there any time to set up working groups to evaluate them or to issue opinions).

5.2.2. Policy developments

In several Member States, the issue has also been addressed at policy level.

a. Strategic documents on gender equality

In some Member States, the issue has been integrated in national and/or regional strategic policy documents on gender equality, therefore framing the issue as gender-based violence or violence against women.

One of the most significant policy developments has been observed in **Belgium**, where obstetric and gynaecological violence has been included in several key strategic documents at federal and regional level.

Box 6: The inclusion of obstetric and gynaecological violence at federal and regional level in Belgium's strategic documents

Belgium National Action Plan to fight gender-based violence 2021-2025[303]

This National Action Plan (NAP) is based on the Council of Europe Convention on preventing and combating violence against women and domestic violence, known as the Istanbul Convention, and on the recommendations addressed to Belgium concerning the implementation of this Convention. It includes 201 measures relating to the federal State, Communities and Regions. Although obstetric and gynaecological violence is not in scope of the Istanbul Convention, the NAP recognises the existence of this form of violence and makes its prevention a necessity. The NAP foresees the creation of a federal working group (that will include professional associations and representatives of health ministers and departments from all regional entities[304]) in order to develop a specific policy in this

[303] Belgian Council of Ministers, National Action plan to combat against gender violence 2021-2025 (*Plan d'action national de lutte contre les violences basée sur le genre 2021-2025)* https://igvm-iefh.belgium.be/sites/default/files/20211125-pan-2021-2025-clean-fr.pdf

[304] The first meeting of this working group should take place in March 2024 (source: interviews with Belgian stakeholders).

area. The NAP also makes reference to the Senate report[305] (that at the time was being written up), as useful in defining the measures to be put in place.

Integration of the issue at regional level

The government of the *Fédération Wallonie-Bruxelles* recognises in its *Plan Droits des Femmes* 2020-2024[306], adopted on 17 September 2020, the reality of obstetric and gynaecological violence. It comprises a measure (1.8.1) on Prevention of gynaecological and obstetric violence. Under this, the regional entity notes that objective and systematic information for young girls and women about their rights, their choices and their possibilities with regard to their bodies (consent to medical procedures, freedom of choice regarding contraception, etc.) must be reinforced within the framework of Compulsory education about relationships, emotional and sexual life (EVRAS) activities in schools, interventions by Psycho-Medico-Social Centers (CPMS) and within the framework of Health Promotion at School (PSE)[307].

Two months later, on 26 November 2020, all the governments of the French-speaking regional entities (*Fédération Wallonie-Bruxelles, Région Wallonne et de la Commission Communautaire Francophone*)[308] set themselves the same objective, adopting the Intra-Francophone Plan to fight violence against women 2020-2024 (*Plan intra-francophone de lutte contre les violences faites aux femmes 2020-2024*)[309].

This Plan identifies obstetric and gynaecological violence as a recognised form of violence. Its Operational Objective 8 (and Measure 27) focuses on the prevention of obstetric and gynaecological violence[310]. The plan recognises the specific nature of this violence, and the need to improve awareness of this issue. It commits to fund initiatives carried out by CSOs to raise awareness on women/patients' rights, train healthcare professionals, strengthen collaboration between healthcare providers and CSOs working on this issue, and deliver specific training to obstetricians and gynaecologists on the issue of obstetric and gynaecological violence. Measure 28 aims at strengthening soon-to-be mothers' knowledge of their rights and of existing mechanisms. For this, the plan foresees actions to strengthen guidelines and training for healthcare professionals who provide support to expecting mothers. Finally, Measure 29 focuses on improving care received during abortion procedures through funding and implementation of training and awareness raising

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305 Belgian Senate, Advisory Committee for Equal Opportunities, Information Report on the right to bodily self-determination and the fight against obstetric violence (*Comité d'avis pour l'égalité des chances du Sénat, Rapport d'information concernant le droit à l'autodétermination corporelle et la lutte contre les violences obstétricales*). Adopted on 2 February 2024, 7-245/1-9, https://www.senate.be/www/?MIval=/Dossiers/Informatieverslag&LEG=7&NR=245&LANG=fr

306 *Fédération Wallonie-Bruxelles, Plan Droit des Femmes,* 2020, http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&g=0&hash=fba5f84be288ad0d20ffc7c6da00b8b6df5d46fa&file=fileadmin/sites/sdec_III/upload/sdec_III_super_editor/sdec_III_editor/documents/Droits_des_Femmes/Plan_Droits_des_Femmes_2020-2024_FWB.pdf

307 Ibid

308 I.e. the governments of Fédération Wallonie-Bruxelles, of the Région wallonne and of the Commission communautaire française.

309 Fédération Wallonie-Bruxelles, Région wallonne et Commission communautaire française, Plan intra-francophone de lutte contre les violences faites contre les femmes 2020-2024, 2020 http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&g=0&hash=d8b3da0904b5dcdae4bcd11756362e9874c77921&file=fileadmin/sites/sdec_III/upload/sdec_III_super_editor/sdec_III_editor/documents/Violence/VF_Plan_intra_francophone_violences_2020-2024_01.pdf

310 Ibid

activities. Following its adoption, a call for projects was launched in 2022[311]. Nine projects were selected, which dealt with the implementation of training for professionals, the organisation of awareness days, the creation of a video game on the theme of gynaecological violence, an awareness campaign targeting medical students, and activities to improve specific groups of women's access to obstetric and gynaecological care[312].

In both plans, the role of civil society organisations was key in putting the issue on the political agenda.

The topic of childbirth and the conditions women face during childbirth is also included in the **Czech Government Strategy for Gender Equality for 2021-2030**[313]. The following problems were identified as crucial (in the field of health): 1) Legislative restrictions on the autonomous work of midwives, which disrupts the possibility of freely choosing the form and place of childbirth; 2) Formal treatment of informed consent and inconsistency in respecting women's right to free and informed decision-making, which in the most extreme cases leads to mistreatment and violence against women in the provision of care; and 3) No satisfactory mechanism that would ensure continuity of care during the six-month period. Postpartum care for the mother and child in Czech maternity hospitals is limited to a period of 72 hours after delivery and is not adequately provided for the remainder of the six-month period. As a result, the share of fully breastfed children is decreasing. The document uses the term "obstetric violence" but not "gynaecological violence".

In **Catalonia (Spain)**, the issue has been addressed in the framework of the fight against gender-based violence.

Box 7: Adopting an inclusive and transversal approach to address gynaecological and obstetric violence – The example of the Catalan Plan to tackle obstetric violence and the violation of sexual and reproductive rights (2023 – 2028)[314]

In **Catalonia (Spain)**, following Resolution 2306 (2019) of the Parliamentary Assembly of the Council of Europe, to act transversally from health policies and equality policies to eradicate this form of gender-based violence, in December 2022, the Catalan Ministries of Health and Equality and Feminisms set up an institutional working group to address obstetric violence and the violation of sexual and

311 Fédération Wallonie-Bruxelles, Wallonie & Francophones Bruxelles, Appel à projets 2022 Relatif à la prévention et à la lutte contre les violences gynécologiques et obstétricales http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&g=0&hash=66c1ecf07baff8d7fa9509f310d1fe80798eb254&file=fileadmin/sites/sdec_III/upload/sdec_III_super_editor/sdec_III_editor/documents/Droits_des_Femmes/Appel_a_projets_VOG_2022/Appel_a_projets_violences_gyneco_et_obst_DEF.pdf

312 "Neuf projets contre les violences gynécologiques soutenus par les entités francophones", RTBF, 10 November 2022, https://www.rtbf.be/article/neuf-projets-contre-les-violences-gynecologiques-soutenus-par-les-entites-francophones-11102109

313 Office of the Government of the Czech Republic, Gender Equality Strategy for 2021 – 2030, February 2021, https://vlada.gov.cz/assets/ppov/gcfge/Gender-Equality-Strategy-2021-2030.pdf

314 Catalan regional government, Action plan on obstetric violence and violeation of sexual and reproductive rights 2023-2028 (*Generalitat de Catalunya, Pla per l'abordatge de la violència obstètrica i la vulneració dels drets sexuals i reproductius 2023 – 2028)*, https://scientiasalut.gencat.cat/bitstream/handle/11351/10977/pla_abordatge_violencia_obstetrica_vulneracio_drets_sexuals_reproductius_2023_2028_2023.pdf?sequence=6

reproductive rights. The group included experts in gender and health, representatives of the Catalan Association of Midwives, the Catalan Society of Gynaecology and Obstetrics, the Health and Gender Advisory Council of the Catalan Ministry of Health and the two existing hospital commissions on obstetric violence in Catalonia.

This group met on a monthly basis with three basic objectives. The first was to produce a report on the legal framework, scientific literature and existing recommendations regarding the approach to obstetric violence and sexual and reproductive rights. Second, an analysis of the current situation in Catalonia was carried out, to identify the perceptions of both users and professionals involved, as well as possible sources of information and indicators. Finally, the group proposed tools to combat obstetric violence and the violation of sexual and reproductive rights, aimed at healthcare service providers, citizens and organisations defending sexual and reproductive rights. The Department of Health of the Government of Catalonia developed the **Plan to tackle obstetric violence and the violation of sexual and reproductive rights (2023 – 2028)**[315], whose mission is to increase the population's knowledge of sexual and reproductive rights to generate structural change that would ensure complete respect and guarantee rights in the field of health, and to provide the necessary tools to professionals.

This plan is made up of four main axes aimed at raising awareness, building the capacity of professionals, improving care and accompaniment, and supporting implementation and monitoring. It has nine strategic objectives and 56 actions. In addition, it has a specific timetable and a budget of seven million euros, running over six years (2023-2028). The plan includes, among other things, the creation of Obstetric Violence Commissions in all health regions of Catalonia, with mechanisms for identifying, reporting and redressing cases of obstetric violence and violations of sexual and reproductive rights. The plan also includes measures to reduce c-sections and other unjustified interventions, promote women's participation in decision-making and improve access to reproductive health care. Providing places for maternity care in non-medical settings and increasing the number of maternity centres is also a key part of the plan. Moreover, it includes actions targeted at specific groups, such as promoting the progressive adaptation of spaces and resources needed to care for people with disabilities or neurodivergence.

This is a pioneering plan at the global level, in line with the standards set by the WHO that reflects a public authority's commitment to understanding and adopting rights-respecting and gender-sensitive healthcare policy[316].

It is also important to note that the plan was well received among healthcare professionals (including The Catalan Society of Obstetrics and Gynaecology and the Catalan Association of Midwives), who actively contributed to its development.

Additional information on the plan is provided in the case study in Annex 2.

b. Initiatives promoted by decision-making institutions to better understand the issues

In a number of countries, decision-making bodies (e.g. Parliaments and governments) have requested information on the issue.

In **Belgium**, in April 2021, a group of senators tabled a request for an information report on the right to bodily self-determination and the fight against obstetric violence. Voted on by a fairly narrow

[315] Ibid

[316] ElNacional.cat, Catalunya impulsa un plan pionero contra la violencia obstétrica: "No se busca acusar, sino mejorar", 18 December 2023. Available at: https://www.elnacional.cat/es/sociedad/catalunya-impulsa-plan-plano-pionero-contra-violencia-obstetrica-no-se-busca-acusar-sino-millo_1136419_102.html

El Periodico, Catalunya tendrá comisiones de "violencia obstétrica" para limitar el alto número de cesáreas, 18 December 2023. Available at: https://www.elperiodico.com/es/sanidad/20231218/cataluna-plan-violencia-obstetrica-puntero-mundo-95977525

majority, the Advisory Committee for Equal Opportunities of the Senate (hereinafter referred to as the "Senate Committee") heard several experts, mainly from the health sector, associations and academia. After two years of work, an information report was drawn up on this basis and adopted by this body on 22 May 2023.The report provides an overview of these types of violence in Belgium and their causes. It also puts forth 92 recommendations aimed at promoting a culture of kindness in gynaecology and obstetrics and combating these forms of violence. The two main associations of obstetricians and gynaecologists—one French-speaking, the other Flemish—first showed opposition to the content of the report, which delayed its adoption (that was supposed to take place in June 2023) until February 2024[317].

In **France**, in 2018, a report was published by the High Council for Equality between women and men (HCE, an independent governmental body), following a request from the Secretary of State for Equality between Women and Men (in 2017)[318]. The report defines gynaecological and obstetric violence as: the "*most serious sexist acts that can occur in the context of gynaecology and obstetrics follow-ups*". It specifies that: "*Sexist acts during gynaecological and obstetrical follow-up are gestures, comments, practices and behaviours carried out or omitted by one or more members of the nursing staff on a patient during gynaecological and obstetrical follow-up and which are part of the history of gynaecological and obstetric medicine, crossed by the desire to control women's bodies (sexuality and capacity to give birth). They are the work of caregivers – of all specialties – women and men, who do not necessarily intend to be abusive. They can take very diverse forms, from the most seemingly innocuous to the most serious*". On the basis of this definition, the HCE identifies six types of sexist act ranging from a failure to take account of patients' discomfort to sexual violence.

Similarly, in **Germany**, following a 2020 request from the CEDAW committee to access statistical data on obstetric violence[319], the Ministry of Health has funded some research (DREAM study) but framed the issue as "subjective birth experience" rather than obstetric violence. In 2021, the Ministry of Family, Seniors, Women, and Youth commissioned a report for recommendations on 'Obstetric violence – how can those affected and the public be best informed?' The report was published in 2022[320], but no information has been identified with regards to the implementation of the recommendations.

In **Luxembourg**, several parliamentary questions have been put forward since 2019. Parliamentary question no. 1292 of October 7, 2019 called upon the Health Minister to enquire about existing data on cases of obstetric and gynaecological violence in Luxembourg; opportunities to develop recommendations; and the potential need to carry out information and awareness campaigns on the prevention and fight against this form of violence against women. In its response, the Ministry of Health (on 8th November 2019) agreed on the need to raise wider awareness on this issue among all

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317 Belgian Senate, Advisory Committee for Equal Opportunities, Information Report on the right to bodily self-determination and the fight against obstetric violence (*Comité d'avis pour l'égalité des chances du Sénat, Rapport d'information concernant le droit à l'autodétermination corporelle et la lutte contre les violences obstétricales*). Adopted on 2 February 2024, 7-245/1-9, https://www.senate.be/www/?MIval=/Dossiers/Informatieverslag&LEG=7&NR=245&LANG=fr

318 HCE, *Rapport du gouvernement français sur les actes sexistes durant le suivi obstétricale et gynécologique*, 2018, https://haut-conseil-egalite.gouv.fr/sante-droits-sexuels-et-reproductifs/actualites/article/actes-sexistes-durant-le-suivi-gynecologique-et-obstetrical-reconnaitre-et

319 CEDAW/C/DEU/QPR/9 (point 16) https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW

320 AKF e.V., Bericht zu den Expertinnengutachten „Information der Öffentlichkeit zu Gewalt in der Geburtshilfe, unter besonderer Beachtung der Bedarfe von Migrantinnen und Flüchtlingsfrauen, https://www.arbeitskreis-frauengesundheit.de/wp content/uploads/2022/06/AKF_Bericht_Informationen_zu_Gewalt_unter_der_Geburt.pdf

professionals and the population and requested an opinion from the Health Scientific Council[321]. Following this request, the Health Scientific Committee published some guidelines for healthcare professionals with a focus on obstetric violence[322]. In July 2021, another two parliamentary questions asked about the definition attributed to obstetric and gynaecological violence and their statistics. The parliamentary question also raised the possibility of establishing a neutral complaints office for victims of gynaecological and obstetric violence. In June 2022, debates in the Parliament on women and children's health also addressed the issue of this form of violence and noted that practices, habits and routines of healthcare professionals should be discussed and questioned. They also criticised the lack of data on the issue.

Similarly, in **Germany**, a parliamentary question was raised in 2020, no. 19/19165 "For a cultural change in maternity care – Women and children at the centre", asking for prevention of obstetric and gynaecological violence[323].

In **Lithuania**, in 2021, the Human rights committee of the Parliament issued a proposal for the Ministry of Health that suggested considering the possibility of establishing the concept of obstetric violence in national legislation and an independent control mechanism[324].

In the **Netherlands**, the stories collected by the Birth Movement through the #Breakthesilence campaign were gathered in a Black Book in 2016, which asked for more attention to be paid to the bodily integrity of pregnant women and their right to informed consent. The report was handed to the Ministry of Health, Welfare and Sport in February 2017. While the Ministry acknowledged the experiences reported by the women and reaffirmed the need for patient-centred care and for involving patients in decision making, it also questioned how representative these views were of the wider population[325].

In **Poland**, the government has not yet taken any action to counteract obstetric and gynaecological violence. However, it is worth mentioning the Report on Perinatal Care in Maternity Units carried out in 2015 by the Supreme Audit Office, and especially the conclusions and recommendations resulting from this audit[326]. Although the term obstetric and gynaecological violence or abuse does not appear throughout the document, the conclusions of the report describe such behaviour as '*The inspected maternity wards did not provide patients and newborns with the required quality of medical services. The regulations regulating the requirements for premises and necessary staff, as well as the standards of perinatal care, allowed for a number of derogations, were applied to an extent inappropriate to the actual*

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321 The Scientific Council for Health is an independent organization, made up of professionals from the medical field, whose mission is to develop and contribute to the implementation of standards of good medical practice. It has a working group focussing on the issue of obstetric and gynaecological violence.

322 Conseil Scientifique Domain de la Santé, *Santé de la Femme Violences Gynécologiques et Obstétricales*, 2021, https://www.cesas.lu/perch/resources/violences-gynecologiques-et-obstetricales.pdf

323 Drucksache 19/19165, https://dserver.bundestag.de/btd/19/191/1919165.pdf

324 See n. 62, *Dėl nevyriausybinių organizacijų kreipimosi „Dėl žmogaus teisių pažeidimų prieš gimdyves*", available at: https://www.lrs.lt/sip/portal.show?p_r=35461&p_k=1&p_kade_id=9&p1=6&p7=4, and https://m.klaipeda.diena.lt/naujienos/lietuva/salies-pulsas/seimo-komitetas-siulo-svarstyti-galimybe-itvirtinti-akuserinio-smurto-savoka-1011110

325 Dutch Government website, Patients' and clients' rights 32 279 Care around pregnancy and birth No 20 Letter From The State Secretary of Health, Welfare And Sport (*Overheid.nl, 31 476 Patiënten- en cliëntenrechten 32 279 Zorg rond zwangerschap en geboorte Nr. 20 Brief Van De Staatssecretaris Van Volksgezondheid, Welzijn En Sport*), https://zoek.officielebekendmakingen.nl/kst-31476-20.html

326 NIK, Report Perinatal Care in Maternity Units, 2016, https://www.nik.gov.pl/plik/id,11621,vp,13972.pdf

needs, and were often even not complied with. These regulations are therefore not an effective tool to ensure an appropriate level of safety for patients and newborns, as well as respect for privacy and dignity'. '*Most of the medical entities inspected did not provide adequate delivery rooms, which resulted in a violation of the patients' right to intimate and dignified medical services, including the inability to administer epidural anaesthesia during vaginal delivery* '. '*The percentage of medical interventions during childbirth was very high, in the inspected units the scale of intervention was even higher than before the entry into force of perinatal care standards and was often several times higher than the average in other developed countries. Every third newborn was fed with modified milk* '. Moreover, in the **Polish** Parliament, the Women's Rights Team (established in 2019)[327] and Parliamentary Team for Perinatal Care (established in 2020)[328] both addressed issues in relation to obstetric care. The former had a working group focusing on maternity care. A total of 20 meetings were held until 23 August 2023, in which decisions were made on: calling for a law decriminalising abortion; condemning the tightening of abortion laws in Poland; calling on the authorities to restore the right of citizens to demonstrate peacefully without harassment, violence and repression; and amendments to the law on violence against women, including domestic, sexual and economic violence. The activities of the Parliamentary Team for Perinatal Care include the evaluation of the actual state of the applied methods of perinatal care in Poland, the analysis of legal regulations applied in other countries, the exchange of information with experts and patients as well as formulating postulates for further changes in national legislation.

In **Czechia**, the Government Council for Equality of Women and Men set up a working group on Obstetrics and Midwifery. The Committee for Obstetrics was established at the Ministry of Health for the purpose of improving obstetrics in Czechia. The first meeting of the Commission took place in November 2021[329].

c. Health-related policy documents and guidelines

In other countries, the issue has been addressed in health-related policy documents, such as in **Germany**, where the 2017 National Health Target around Birth (*Nationales Gesundheitsziel rund um die Geburt*) was built around an evidence and rights-based approach.

National guidelines have also been produced to improve obstetric and gynaecological care.

In 2020, in **Czechia**, the Methodological recommendation of the Ministry of Health for providers of healthcare services in the field of gynaecology, obstetrics and neonatology was published in the official Gazette of the Ministry of Health[330]. It proposed that the organisational structure and staffing capacity is re-organised within the existing maternity hospital. This recommendation aimed at improving the care for pregnant women and their "*humanisation*" and implemented many of the WHO recommendations in the field of childbirth and prenatal care. However, in the Gazette of the Ministry of Health (No. 12/2022), this methodological recommendation was cancelled without compensation[331]. Neither the website of the Ministry of Health nor the website of the Czech Medical Chamber mentioned

[327] Women's Parliamentary Group, https://www.sejm.gov.pl/sejm9.nsf/agent.xsp?symbol=ZESPOL&Zesp=593

[328] Parliamentary Team for Perinatal Care, https://www.sejm.gov.pl/sejm9.nsf/agent.xsp?symbol=ZESPOL&Zesp=728

[329] Details about the outputs of this expert group is not available.

[330] Ministry Of Health, *Concept of home care*, 2020 (*Ministerstva Zdravotnictv, Koncepce domácí péče, 2020*), https://mzd.gov.cz/wp-content/uploads/2020/10/Vestnik-MZ_11-2020.pdf.

[331] Ministry Of Health, Specific Treatment Programs Approved By The Ministry Of Health In The Period July – September 2022 (Ministerstva Zdravotnictv, Specifické Léýebné Programy (Slp) Odsouhlasené Ministerstvem Zdravotnictví V Období Ýervenec – Záěí 2022), https://mzd.gov.cz/vestnik/vestnik-12-2022/

any methodology, recommendation or definition of standards for care in gynaecological or obstetric care (with the exception of WHO recommendations for obstetric care that are available on the Ministry of Health website).

The Ministry of Health of the **Slovak Republic** has adopted standards for the care for pregnant women: *Care of a low-risk mother during childbirth*[332]. The document presents the principles of modern care for women during childbirth and pregnancy that are in line with WHO recommendations. Nevertheless, the document does not address obstetric and gynaecological violence and neither uses the term "violence" (although a number of measures proposed in the document would clearly have positive effects on the incidence of obstetric violence). The Ministry of Health frames these recommendations as aiming to provide better quality healthcare to pregnant women[333].

In **France**, in July 2022, in a context of numerous testimonies and complaints about gynaecological violence, some giving rise to legal investigations, the Prime Minister commissioned the National Consultative Ethics Committee (CCNE) to reflect upon the question of consent during gynaecological consultations and on how to restore trust between caregivers and patients. In an opinion issued in March 2023, the CCNE pledged for "*revisited and adapted consent*" and called on caregivers to pay increased attention to interpersonal skills, precaution and tact at each stage of the medical examination[334]. Additional precautions must also be taken "*when students carry out or attend examinations*" or in the presence of a patient "*in a particularly vulnerable situation*". The committee also called for better training for medical students "*in the humanities and ethics of care*" and recommended including the right to refuse an examination in the Public Health Code[335].

In the **Netherlands**, guidelines on maternity care have been developed for situations when pregnant women refuse recommended care[336]. The guidelines state that in these situations, attention and respect for the wishes of the patient is important, without judgement, and requires advanced communication skills. The goal is to provide as much information as possible to the pregnant woman, and to ensure she understands it and the alternatives that are available to her. The final decision belongs to the pregnant woman. Research shows that a patient's decision to oppose recommended care is often due to negative experiences of care during the current pregnancy or during a previous one[337]. These guidelines have become an important tool to reflect upon obstetric violence and have facilitated the process for pregnant women to access care outside of clinical guidelines[338].

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[332] Standard Practices, Caring for the Low-Risk Parent during Childbirth (*Štandardné postupy, Starostlivosť o nízkorizikovú rodičku počas pôrodu*),file:///C:/localdata/daxanei/Downloads/8_1-Prenatalna-starostlivost-o-nizkorizikovu-rodicku-pocas-porodu-Gyn-a-por.pdf

[333] Ministry of Health, Improving maternal and childcare (*Ministerstvo zdravotníctva, Skvalitnenie starostlivosti o matku a dieťa*), 2021, https://www.health.gov.sk/Clanok?standard-postup-matka-dieta

[334] National consultative ethics commitee, opinion 142, Consent and respect for the person in the practice of gynaecological examinations and examinations affecting intimacy (*Comité consultatif national d'éthique, Avis 142, Consentement et respect de la personne dans la pratique des examens gynécologiques et touchant à l'intimité*), 2023, pp. 38. https://www.ccne-ethique.fr/fr/publications/avis-142-du-ccne-consentement-et-respect-de-la-personne-dans-la-pratique-des-examens

[335] Ibid

[336] Royal Dutch Organisation of Obstetricians & Dutch Society for Obstetrics & Gynaecology, Obstetric care guidelines, (Koninklijke Nederlandse Organisatie van Verloskundigen (KNOV) & Nederlandse Vereniging voor Obstetrie & Gynaecologie (NVOG), Leidraad 'Verloskundige zorg buiten richtlijnen'), 2015, https://www.nvog.nl/wp-content/uploads/2018/02/Leidraad-Verloskundige-zorg-buiten-richtlijnen-1.0-30-11-2015.pdf

[337] Hollander, M., de Miranda, E., van Dillen, J., de Graaf, I., Vandenbussche, F. and Holten, L., *'Women's motivations for choosing a high-risk birth setting against medical advice in the Netherlands: a qualitative analysis'*, BMC pregnancy and childbirth, 2017, 17(423), pp.1-13. https://bmcpregnancychildbirth.biomedcentral.com/counter/pdf/10.1186/s12884-017-1621-0.pdf

[338] Proof of this improvement is that one of the biggest hospitals in Amsterdam has in their job-application for new midwives as a requisite that they 'must like to care for people who wish to go outside of guidelines', which was unimaginable a couple of years ago, https://www.werkenbijolvg.nl/vacatures/

6. IMPROVING ACCESS TO JUSTICE

Key findings

In the absence of distinct provisions, women who experienced obstetric and gynaecological violence must rely on existing judicial (civil or criminal) and extra-judicial avenues (compliant with the hospital or the healthcare system, mediation, disciplinary proceedings, compensation).

However, evidence seems to suggest that patients rarely use them.

The reasons for that are to be found in the lack of societal recognition and awareness of the phenomenon as a form of violence and in the fact that these actions are not designed to address obstetric and gynaecological violence as a specific form of gender-based violence, in addition to it not being recognised legally, as referred to above.

Victims therefore refrain from seeking justice for different reasons: disbelief in the effectiveness of these procedures; fear of experiencing revictimization (also because of stereotypes, sexism, condescension and paternalism, still widespread in both healthcare and courts); costs and length of judicial proceedings; the difficulty of finding a lawyer specialised in the issue, etc.

Again, civil society organisations play a key role in supporting women's access to justice.

6.1. Existing mechanisms at Member State level

Since no distinct provisions exist against obstetric and gynaecological violence in Member States' legal systems, as explained in Section 5, victims must rely on existing judicial or extra-judicial avenues. However, while technically applicable, these actions are not designed to address obstetric and gynaecological violence as a specific form of gender-based violence. The cases brought before the Committee on the Elimination of Discrimination against Women[339] show that complainants are forced to approach the Committee for redress because unable to secure access to justice through the national legal system.

On the paper though, national legal actions potentially applicable are, as mentioned, numerous.

6.1.1. Judicial avenues: civil and criminal proceedings

While criminal proceedings could be based on one or more of the criminal offences listed under Section 5.1, civil proceedings would be based:

- either on contractual liability: healthcare professionals and institutions must respect any contractual obligations they may have. The court will decide whether the hospital or the healthcare professional directly failed to meet their obligation while providing care and decide on financial compensation (if any).

- or on extra-contractual liability the healthcare professionals and institutions might incur in the event of damage caused to others through their fault or that of persons for whom they are responsible.

According to the desk research conducted at national level, it appears that very few cases are brought and most of them are aimed at obtaining compensation for bodily harm only. Compensation for

[339] See for instance SFM v Spain CEDAW/C/75/D/138/2018.

gender-specific harms has proven difficult to obtain in courts, not to mention that monetary compensation may not provide meaningful redress for some victims of obstetric and gynaecological violence. Furthermore, victims have to prove the fact, and this is a complex and onerous task, particularly when it comes to proving the causal link between the wrongful act and the harm (burden of proof in medical matters). This difficulty is linked in particular to the fact that childbirth often involves a cascade of medical acts. Finally, reliance on these avenues decontextualises obstetric and gynaecological violence as a form of gender-based and structural violence, instead, suggests they are individual issues between women and their healthcare providers[340].

6.1.2. Extra-judicial avenues

a. Filing a grievance with the hospital

Every hospital has a procedure to address patients' concerns or complaints. Hospitals have the authority to investigate and take corrective or disciplinary action (e.g. limit or remove healthcare professionals' ability to practice at that facility). However, these are consumer complaints and therefore it is up to the hospital whether or not to respond to them and how. Besides, such procedures do not automatically trigger reporting to professional boards or to healthcare agencies. Compared to the judicial avenues, these types of complaints generally have no costs, apart from some administrative costs (e.g. those involved to obtain copies of medical records to be annexed to the complaint).

b. File a complaint with the healthcare system[341]

This can be done through the healthcare portal or through a specific agency for patients' complaints, which both usually require the patient to fill in an online form. However, in most Member States, obstetric and gynaecological violence is not listed in the drop-down menus for complaints (in case of a portal or an online form), as reported in **Denmark**, for example. Furthermore, one can mostly complain against unfair actions or administrative malpractice, not against a clinical judgement, as it happens in **Ireland** before the Health Service Executive (HSE) that manages the public health system, and consequently any complaint about healthcare services.

Box 8: Example of the complexity of reporting mechanisms: The case of Portugal

In **Portugal**, complaints can be received through the several routes: the Health Regulation Authority (ERS – *Entitade Reguladora da Saude*)[342], 'Yellow book' (for public healthcare), 'red complaint book' (private healthcare) and boards of healthcare practitioners – and, if applicable, hospital mediation or ombudsman). Given the complexity of those routes, the Portuguese Observatory for Obstetric Violence (OVO) has available information on their website on how to process to file a complaint on obstetric violence[343]. Most women only know the "complaint book", which is often disregarded because it requires them to write a complaint *in loco* when they are still suffering from mistreatment.

[340] Caruso, E., Pickles, C. & Herring, J. (eds.), 'Women's Birthing Bodies and the Law. Unauthorised Intimate Examinations, Power and Vulnerability', *Fem Leg Stud*, Vol. 30, 2022, pp.125–128. https://link.springer.com/article/10.1007/s10691-021-09475-1#citeas

[341] Please note that this is not a complete list of examples across the EU.

[342] The Portuguese Health Regulatory Authority is the independent public body responsible for the regulation and supervision of the activity of health care providers in Portugal.

[343] OVO Portugal, *Passos Jurídicos para reagir em caso de Violência Obstétrica*, https://ovoportugal.pt/passos-juridicos/

There is also a time limit for patients to make their complaints, which depends on the type of complaint and on the entity they are complaining to, and there is limited support for women who want to file a complaint. The citizen's offices (*Gabinetes do cidadão*) are present in some hospitals, but function as a 'mediation' entity (limiting formal complaints).
Additional information is available in Annex 2.

c. Disciplinary proceedings before the medical board, the board of gynaecologists, or midwives[344]

State-licensed professionals like physicians and midwives are regulated by boards, generally composed of their peers, which do not guarantee the independence and impartiality of the decision. When a patient has a complaint about the care they received from one of these professionals, they can ask the board to investigate and potentially discipline the professionals, up to and including removing their license to practice. Often, there is a time limit for filing a complaint after the event has occurred, as well as for the board to complete an investigation and take action. In most Member States, there are no costs for this type of complaints, apart from those involved in obtaining copies of medical records to be annexed to the complaint. In **Cyprus**, submitting a complaint to the Cyprus Medical association costs 100 euros, which can present a barrier to accessing justice.

d. Compensation for damages via specific funds[345]

Victims of obstetric violence may also apply for **compensation for damages** resulting from healthcare **via a specific fund**. In **Belgium,** it is possible to obtain compensation for certain "sufficiently serious" injuries caused by a "no-fault medical accident". There is no need to prove the fault of the decision but the link between the decision and the damage should be proven, which is far from easy in cases of obstetric violence. In **Austria**, if innocence can be proven yet demonstrable damage has nevertheless occurred, compensation can be claimed from the patient compensation fund.

e. Mediation[346]

Recourse to mediation is voluntary for both parties and does not entail any costs. Often the mediation is a service of the hospital concerned. Mediators are legally bound to a duty of confidentiality and impartiality. However, research has shown that usually, patients have strong doubts about the independence of the procedure given that mediators are often employed by the healthcare establishments where the healthcare professionals in question work.

In **Austria,** a more independent form of mediation is offered to all patients: a complaint can be filed with patient/care advocates who are independent, non-institutional organisations that protect the rights and interests of patients. Their responsibilities extend primarily to hospitals, nursing homes and mobile healthcare services, and in some federal states, also to practicing doctors and other health and social services institutions. The respective patient/nurse advocate is responsible for the healthcare facilities in their own federal state.

Mediation is considered mostly useful for minor damages but not in more serious cases. The use of an alternative dispute resolution, including mediation, is generally not recommended for cases of violence

[344] Please note that this is not a complete list of examples across the EU.
[345] Please note that this is not a complete list of examples across the EU.
[346] Please note that this is not a complete list of examples across the EU.

against women. This is firstly, because the victim of violence might be intimidated by the perpetrator as a result of the violence experienced and therefore cannot participate on an equal level with the perpetrator, and secondly, due to the hierarchical patient-doctor relationship specific to obstetric and gynaecological violence[347].

Complaints can be also filed to the **ombudsman**, whether that be a special ombudsman for patient rights or the national ombudsman, however, their focus lies on maladministration (including discrimination and abuse of powers), and does not touch upon medical decisions.

6.2. Limited data on effectiveness of mechanisms to access to justice

It is difficult to measure whether the existing complaint systems guarantee victims' access to justice as official data on cases of obstetric violence are collected in a limited number of Member States at national level through those reporting mechanisms. Such examples have been identified in **Sweden** and **Portugal**, and at the regional level in **Spain (Catalonia, see section 5.2.2)**.

Box 9: Example of data collection on obstetric and gynaecological violence

Sweden and the patient insurance In Sweden, LÖF patient insurance (national body) will compensate patients who suffered from avoidable injuries. The Patient Injury Act of 1997 mandates that all Swedish caregivers (public and private) subscribe to this insurance[348]. Löf is a mutual insurance company, owned and financed by the 21 regions. Conditions for accepting or declining a claim are stated in the Patient Injury Act, and the terms of compensation for avoidable injuries are stated in the Tort Liability Act of 1972 (SFS 1972:207).

In the years 2020–2022, Löf received 5,400 claims related to **obstetric and gynaecological issues** in patients 16 years and older, and 1,900 of these claims (35.2%) were judged as avoidable and thus compensated. The remaining were judged as unavoidable by today's standards, and thus not compensated. It is difficult to state how many of these cases fall directly into the category of obstetric and gynaecological violence as some cases might have happened with the patient's full information and consent.

Box 10: Portugal and the new category recognising obstetric violence in the Health Regulation Authority

In Portugal, the Health Regulation Authority (ERS) now has a category of "obstetric violence complaints". ERS began to publish, in addition to complaints, the decisions on the Administrative Proceedings and the Precautionary Measures adopted during the fourth quarter of 2021. The trimestral report now includes the classification "obstetric violence complaints" and in the last trimester of 2021, two cases mentioned obstetric violence[349].

In **Cyprus**, the Federation of Patients' Associations (CyFPA) runs an Observatory for Patients' Rights and complaints can be filed either via a helpline (1403) or by filling in an online form. CyFPA Observatory's data are published in monthly reports. According to October's report (CyFPA Observatory, 2023), one of the 53 recorded complaints of the month concerned a gynaecologist who recommended an unnecessary (as it turned out later) surgery[350].

[347] Article 48 of Istanbul Convention sets a prohibition of mandatory alternative dispute resolution processes, including mediation and conciliation, in relation to all forms of violence covered by the Convention. This does not include mediation based on informed, free and ongoing will of all participants.

[348] Patient Injuries Act (SFS 1996:799), https://lof.se/filer/PSL-from-2021-07-01.pdf

[349] ERS, Publicação de Deliberações – 4.º trimestre de 2021, https://www.ers.pt/media/.pdf

[350] CyFPA, Monthly Statistics of the Patient Rights Observatory – October 2023, available at: https://cypatient.org/en/

In addition, data from different studies show that women victims of obstetric and gynaecological violence rarely file a complaint. For example, according to the 2018 report on the Monitoring of maternity and perinatal care in **Poland**, during childbirth, 54.3% of women experienced violence or abuse. However, only 15.5% of respondents believed that some of their rights had been violated during their stay in the hospital, and only 3% of women decided to file a complaint.

6.3. Identified barriers that women face when seeking justice

As the Polish example mentioned above shows, despite important developments, obstetric and gynaecological violence is yet to be reckoned with legally and socially in Europe. The section below describes the main barriers women face when seeking justice[351].

6.3.1. Difficulties for women (and practitioners) to recognise those practices as 'violence'

The main barrier identified across Member States is the lack of awareness on what obstetric and gynaecological violence is, which translates to limited support for women to be able to identify violations of their rights and make their case. The lack of social (and legal) recognition of this form of violence leads to ignorance, from both patients and healthcare providers, of women's rights when it comes to gynaecological and obstetric care, and consequently to reticence by victims to seek justice.

Healthcare providers are reticent to recognise this form of violence because they do not recognise themselves in these behaviours—which do not correspond to their professional ethics—and therefore, do not claim that any malicious intent is involved (see Section 7).

Without recognition at various levels of society, the notion that obstetric and gynaecological violence is not a common phenomenon during childbirth, and only an isolated, exceptional incident that might happen from time to time, is perpetuated. This limits the possibility to address it at a policy level.

6.3.2. Structural barriers

Yet even in cases where women recognise that they have been a victim of this violence, various structural barriers prevent them from being able to file a complaint.

Some complaints processes require improper care to be reported within a specific timeframe[352]; given how under-acknowledged this form of violence is, many often do not recognise the violence in due time and even if they do, filing a complaint in such a short amount of time is difficult alongside raising a newborn or recovering from the violence. As a result, few cases are made and those that are filed are often not documented enough to meet the requirements (and get refuted as being necessary medical procedures to save lives). For example, in **Slovenia**, women are only given 15 days to file a complaint

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[351] Ayres-de-Campos D., Louwen F., Vivilaki V., Benedetto C., Modi N., Wielgos M., Tudose M., Timonen S., Reyns M., Yli B., Stenback P., Nune, I., Yurtsal B., Vayssière C., Roth G., Jonsson M., Bakker P., Lopriore E., Verlohren S., Jacobsson B., *European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG)', European Midwives Association (EMA). Joint position statement: Substandard and disrespectful care in labour - because words matter, European journal of obstetrics, gynecology, and reproductive biology,* Vol. 296, 2024, pp.205-207. https://www.semanticscholar.org/paper/European-Association-of-Perinatal-Medicine-(EAPM)%2C-Ayres-de-Campos-Louwen/ac5909893d8c6e331cb3574f798762f5b2a26bcf

[352] Slovenian Republic, Complaints procedure for dealing with violations of patients' rights (*Pritožbeni postopek za obravnavo kršitev pacientovih pravic*), https://www.gov.si/zbirke/storitve/pritozbeni-postopek-za-paciente/

for improper conduct and 30 days for improper care[353]. The majority of women who shared their experiences in the 'Me Too during childbirth' campaign in **Finland** felt that the timeframe for making a complaint was too short, and the process too difficult to follow. These structural impediments are exacerbated by the fact that women suffering from trauma-related symptoms and caring for newborn babies do not feel able to undertake the task of complaining against powerful institutions and authorities. In **Portugal**, most women are aware of the 'complaint book', yet this is often disregarded because it requires to write a complaint *in loco* when they are still suffering from mistreatment (and have just given birth)[354].

One additional barrier relates to the limited knowledge women have on how to report this violence. In **Finland**, it was reported that several women did not even know that such complaints could be filed, or that hospitals had ombudsmen. Maternal and Childcare services do not educate women on the possibility of filing complaints and most women who had tried to express to their maternal healthcare nurse that their birthing experience had been traumatising, had faced belittling. Furthermore, in **Denmark**, there is limited information on how to complaint about abuses during obstetric or gynaecological care, leaving it up to the family to find their way of reporting.

Limited knowledge on how to access medical files/information and collect evidence constitutes another barrier. In **Spain**, it has been identified that women's clinical documentation is not usually handed over in full and, if it is, it has been found that on many occasions, certain interventions or acts, such as the Kristeller manoeuvre, are not reflected and the completion of the partogram[355] is usually poor[356]. This barrier is linked to another one; the burden of proof in medical matters. Victims have to prove the causal link between the wrongful act and the harm, which becomes an onerous and complex task in the face of childbirth which inherent involves 'a cascade of acts'. Further, challenging the responsibility of healthcare professionals is made difficult by limited legal and medical knowledge and by the pathologisation of childbirth and trivialisation of medical interventions[357].

In addition, women who have experienced this violence do not complain or do not file a complaint because they often feel shame or guilt, while others are traumatised and no longer want to think about the traumatic event. The narratives of women who shared their experiences in the 'Me Too during childbirth' campaign in **Finland** revealed that they could not even bear the idea of walking back into the hospital in which they had been abused during childbirth[358]. Fears over future mistreatment were also identified in **Poland**. In a study conducted by the Childbirth with Dignity Foundation, women's statements show that they are afraid to report violence because they are afraid that the same facility/doctor will not provide them with proper care in the future (and the choice of facilities or doctors is often limited)[359]. The Association for Improvement in the Maternity Services in **Ireland** advise that complainants may require research, information and support, and may need to attend a meeting to discuss the complaint, which can be very stressful[360]. In addition, filing complaints often does not

[353] Ibid

[354] Portuguese case study.

[355] A 'partogram' is a composite graphical record of key data (maternal and foetal) during labour entered against time on a single sheet of paper. It is used as a labour monitoring tool to detect difficulties early, allowing for referral, intervention, or closer observations to follow.

[356] Ministerio de Sanidad, Servicios Sociales e Igualdad, *Informe Sobre la Atención al Parto y Nacimiento en el Sistema Nacional de Salud*, 2012, https://www.sanidad.gob.es/organizacion/sns/planCalidadSNS/pdf/InformeFinalEAPN_revision8marzo2015.pdf

[357] Borges M.T., *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, *Duke Law J.*, Vol. 67, No 4, 2018, pp.827-862. https://pubmed.ncbi.nlm.nih.gov/29469554/; Jassogne P., *Les violences gynécologiques et obstétricales : médecine et droit sous le prisme du genre*, Faculté de droit et de criminologie, Université catholique de Louvain, 2020. https://dial.uclouvain.be/memoire/ucl/en/object/thesis%3A26508

[358] Minä myös synnyttäjänä, https://www.facebook.com/MinaMyosSynnyttajana/

[359] Fundacja Rodzić po Ludzku, *Mistreatment and violence against women during reproductive health care with a focus on childbirth : Poland*, https://view.officeapps.live.com/op/

[360] AIMS Ireland, https://aimsireland.ie/requesting-your-birth-notes-and-making-a-complaint/

result in their experiences being validated since the violence is often masked as 'necessary for saving lives', creating a deterrent for women seeking justice.

Finally, one key barrier is linked to the complications inherent in navigating the legal system. Specifically for a lawsuit filed with a (civil or criminal) court of law, the system itself and the complexity of the legalities are intimidating for the victims, especially since the victims will most likely face hostility from the other party, including questioning their story or blaming them for their own injury or assault. Secondly, lawyers usually will not take cases involving harm during gynaecological and obstetric care unless the violation is clear cut and well-documented, and the resulting damage was both significant and measurable. Thirdly, because harm in childbirth or during obstetric and gynaecological consultation is an emerging area of practice, it may be difficult to find a lawyer with the right kind of experience or willingness to learn about this kind of law. Fourthly, lawsuits are expensive and take a long time to resolve (usually years). There are filing fees, professional fees, and various fees related to compiling, analysing and presenting evidence, and there are often months in between court dates.

6.3.3. Organisational obstacles

Patients have strong doubts about the independence of procedures given that they are often employed by the healthcare establishments where the health professionals in question work. For example, in **Belgium**, several experts have raised concerns about the composition of the councils of the Medical Board, made up exclusively of doctors, which does not guarantee its independence and impartiality[361]. Similarly, in **Luxembourg**, women who have experienced obstetric and gynaecological violence can report directly to hospital, but this is not a neutral place, and there is no independent mechanism where women can file a complaint.

6.3.4. Barriers faced by specific groups of women

As discussed in Section 3, some groups of women are more at risk of experiencing obstetric and gynaecological violence. These groups also face additional barriers when it comes to accessing justice. The barriers identified above are exacerbated for marginalised women who face added stereotypes and stigma, and often lack medical insurance, the necessary language and/or literacy skills and the financial resources to navigate these powerful and labyrinthine bureaucratic structures. This is particularly the case for Roma women, low-educated women, women with disabilities, migrant women and allophone women.

The narratives of women who have shared their experiences in the 'Me Too during childbirth' campaign in **Finland** are testament to the added challenges that are posed to marginalised women when accessing complaint mechanisms. Of the women who shared their stories, 11 had filed a complaint with the hospital, and five had followed it up with a reminder to the Regional State Administrative Agencies. The majority of the women felt that the timeframe for making a complaint was too short, and the process too difficult to follow. Those that had made complaints agreed that the process was complicated. Complaints cannot be made by email or through the internet, but must be sent by mail, which differs from every other official and government related form. Language barriers, little knowledge of the legal system and limited time prevents marginalised women from taking action beyond the mediation offered.

Discrimination against Roma women in health care is particularly evident in maternity wards and emergency care. There are various reports by the European Roma Rights Centre (ERRC) about human rights violations against Roma women in healthcare services. In one case, a pregnant Roma woman was bleeding and experiencing abdominal pain but was denied care by emergency aid and her GP.

[361] Belgian Advisory Committee for Equal Opportunities of the Senate, Information Report adopted on May 22, 2023 (*Rapport d'information du Comité d'avis pour l'égalité des chances du Sénat*), ibid, p. 24.

Two days later she found out that the foetus was no longer alive, but after filing a complaint, she received no compensation or information about her complaint.

In **Czechia**, marginalised women are prevented from making complaints due to many structural factors. A study on migrant women in Czechia found that their situation of accessing justice in Czech maternity hospitals is complicated in particular by insufficient access to health insurance, the absence of social support, language barriers and also prejudices on the part of doctors[362].

Costs associated with the submission of the complaint can also act as a deterrent for women with limited economic resources. In **Cyprus**, complaints regarding breaches of patients' rights can also be addressed to the Cyprus Medical Association but the submission of the complaint costs 100 euros.

In **Malta**, women with disabilities face additional barriers, including non-friendly access to complaints, and special assistance is unavailable on occasion.

Sweden has a national complaint system through The Health and Social Care Inspectorate (IVO), which has independent review boards for gynaecology and obstetrical care, meaning the people on the committee reviewing the case will be experts knowledgeable in the speciality. Though a complaint can be launched online, and the form is easily accessible, the homepage is not accessible in minority languages. In addition, complaints filed through the Patient Advisory Committee are regionally organised and most of the regions' homepages are not available in any other language but Swedish (sometimes English) excluding those who cannot speak the language to access the information.

6.4. Role of CSOs in fostering better access to justice

Assistance to victims for filing a complaint is mostly provided by a specific patient's rights office, set up in accordance with the legislation on patients' rights in the hospital (e.g. **Cyprus**) or specific independent committees with national or regional competence (e.g. **Sweden**).

However, in addition to having led many initiatives to show the structural nature of obstetric violence and the limits of the instruments described above to address the related issues, all across Europe, CSOs also provide support to women victims of obstetric violence in accessing to justice[363].

The **Austrian** Birth Alliance, a private initiative, has compiled information material for women about violence in obstetrics and provides information about patient rights[364]. It also specifies the process for filing a complaint to the clinic about experiences surrounding birth and provides a letter template to facilitate this process. It also recommends patient lawyers who serve as mediators between patients and the hospital and represents concerns free of charge.

In **Germany**, a former surgeon founded the association Traum(a)Geburt e.V. for women having experienced violence during childbirth after her own traumatising experience, which she said was exacerbated by the violent structures she faced when trying to seek help and justice afterwards.

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362 Pařízková A., Hrešanová E. Glajchová A., *Migrace a porod: sociální aspekty prolínání dvou životních změn ve výzkumu perinatálního zdraví žen,* Sociologický časopis / Czech Sociological Review, Vol. 54, No. 1, 2018, pp. 3-34. https://sreview.soc.cas.cz/artkey/csr-201801-0003_an-intersection-of-two-life-changes-in-social-x2011-science-research-on-women-s-health.php

363 Less examples of CSOs providing support to women in case of gynaecological violence have been identified, reflecting once more (in addition to the lack of data highlighted in section 2) the limited visibility given to this specific form of violence.

364 GEBURTSALLIANZ ÖSTERREICH, https://www.geburtsallianz.at/patientenrechte-2/

Assault, coercion or violations of right to informed consent can be pursued but are difficult to prove in both criminal and civil lawsuits, and so Traum (a) Geburt e.V. gives counselling to pregnant women, helps traumatised women and provides legal advice[365].

The Association for Improvements in the Maternity Services **Ireland** (AIMSI) offers support to people who have been adversely affected by their experience of the Irish Maternity System via a support team and support network[366]. They support justice for survivors, citing important public cases such as The Ciara Hamilton Case in Kerry, Mother A case in Waterford and the Ms B case in Cavan. They have extensively represented the views of service users at various strategies, including The National Maternity Strategy (2016-16), The Specialist Strategy for Perinatal Mental Health (2017), HIQAs Standards for Better Safer Maternity Services (2016), External Advisory Group for The Women's Aid Maternity Project (2021-2022) and Programme Board member for the National Maternity Experience Survey (2020-21).

In the **Netherlands**, the Birth Movement (Geboortebeweging[367]) is a group led by mothers and supported by midwives. It mainly consists of a very active Facebook group, counting a couple of thousand members, where pregnant women can ask questions and were vivid discussions take place. They core group holds regular meetings. They also react to developments within midwifery and maternity care. On their Facebook page they offer support to pregnant women and a phone service available 24/07. Each year, they organise an action #genoeggezwegen addressing violence and abuse by care workers.

In **Poland**, women can apply for psychological help and legal support in the event of being victims of obstetric violence to Centre for Women's Rights[368], Childbirth with Dignity Foundation[369], FEDERA Foundation for Women and Family Planning[370] and Matecznik Foundation[371].

Box 11: Developing a network of local activists to build capacity in Poland

The **Childbirth with Dignity Foundation** (see A1.3) carries out activities to monitor the provision of perinatal care, by collecting data from women; defending and protecting women women's rights; raising awareness of both women and medical staff; and providing direct support to women.

Since 2019, Childbirth with Dignity Foundation has been developing a network of local activists – The *Guardians of giving birth with dignity*. Thirty-five activists from all over Poland were trained to foster women's social participation by encouraging them to complete the "Voice of Mothers" survey after giving birth and raise women's and local communities' awareness on their rights in perinatal care. They are also invited to hospitals and healthcare facilities to present perinatal care from the women's perspective. Thanks to their unique knowledge of local conditions, the Guardians can take action for change more effectively and support long term improvement in the quality of care[372].

365 Traum(a)Geburt e.V., https://traumageburtev.de/

366 AIMS Ireland, https://aimsireland.ie/aimsi-submission-to-joc-on-gender-equality/

367 https://www.geboortebeweging.nl/

368 Centrum Praw Kobiet, https://cpk.org.pl/

369 Fundacja Rodzić po Ludzku, https://rodzicpoludzku.pl/

370 FEDERA, https://federa.org.pl/

371 Fundacja Matecznik, https://fundacjamatecznik.pl/

372 Fundacja Rodzić po Ludzku, *Strażniczki Rodzić*, https://rodzicpoludzku.pl/interweniujemy/strazniczki/

In **France**, a project has been launched in 2014 to collect testimonies of obstetric violence ('*Project TVO : témoignages de violences obstétricales*') with the aim to draw a map intending to show the different forms of obstetric violence experienced by women, and provide information on the place where such incidents happened. The map also aims at helping research carried out on obstetric violence[373]. In **Cyprus**, the Birth Forward, an NGO has been granted a funding in 2023 in order to implement the Respect WATCH project. It aims to establish a national advocacy and a watchdog mechanism to monitor if perinatal care is delivered with respect. As stated in the projects' summary, its target is to establish "*tools, systems and procedures to systematically record, code, analyze in order to identify patterns and gaps, advocate for redressing those gaps through reporting and recommendations to stakeholders*"[374].

It is worth noting that limited initiatives focusing specifically on gynaecological violence have been identified, and that support provided by CSOs seems to focus on obstetric violence.

[373] Témoignages de violences obstétricales, *Carte des violences obstétricales*, https://temoignages-violences-obstetricales.fr/

[374] Birth Forward, RespectWATCH: Developing an Advocacy Strategy and WatchDog Mechanisms to ensure Respectful Maternity Care (RMC) in Cyprus, https://www.birthforward.com/

7. ADDRESSING RESISTANCE AND IMPROVING AWARENESS OF HEALTHCARE PROFESSIONALS

Key findings

Data collection at EU and Member State level has shown that overall, healthcare professionals are resistant to frame the issue of obstetric and gynaecological violence as a form of systemic gender-based violence and would prefer using more 'positive' terminology. However, by doing so, there is a risk that the root causes of obstetric and gynaecological violence remain invisible.

Obstetric and gynaecological violence should not be assimilated to medical malpractice or negligence. It is a structural problem that needs to be addressed in a comprehensive manner, moving beyond contextual and logistic issues by showing how it impacts on women's human rights, equality, health and reproductive autonomy.

Issues in relation to the provision of obstetric and gynaecological care are not ignored by healthcare professionals, and many do acknowledge the importance of addressing the issue.

Some initiatives have been taken to improve healthcare professionals' understanding of the issues at stake (including professional guidelines, protocols for healthcare professionals to raise awareness on obstetric and gynaecological violence, harmful practices, etc.), or to foster positive changes in their work (including training and capacity building to help them adopt a more gender-sensitive approach to their work and transform normalised practices).

7.1. A difficult recognition of the phenomenon among healthcare professionals across the EU

Growing recognition of this form of violence at international and European level has led healthcare professionals to position themselves. However, research carried out in the 27 EU Member States has identified dissensions among different healthcare professionals on how to frame this issue, and how (and if) to tackle it.

7.1.1. Reject of terminology 'violence' and underlying power structures

Data collection in the 27 EU Member States together with interviews carried out with professionals shows that overall, most resistance has been identified among obstetricians and gynaecologists on how to frame the issue.

In some Member States, there is strong opposition to the use of the term 'violence', which appears problematic, for several reasons. Several federations and associations of healthcare professionals (obstetricians and gynaecologists) have positioned themselves against the terminology used to describe what they consider as individual malpractice that is not systemic[375]. Obstetricians and

[375] Ayres-de-Campos D., Louwen F., Vivilaki V.,Benedetto C., Modi N., Wielgos M., Tudose M. P., Timonen S., Reyns M., Yli B., Stenback P., Nunes I., Yurtsal B., Vayssière C., Roth G. E., Jonsson M., Bakker P., Lopriore E., Verlohren S. Jacobsson B., *European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists*

gynaecologists view the term 'violence' as unnecessarily provocative and argue that using this term risks alienating healthcare workers by implying that any mistreatment caused is intentional.

In a response to reported obstetric violence from an online community survey in **Italy**, presidents of three obstetrician and one midwifery associations objected to the evidence, calling the use of the term "*deplorable*" as it is "*damaging*" and "*alarming*" to put "*violence*" next to "*obstetric*". They state that the findings "*do not take into account the power-duty of the professionals to co-decide, guide women's choices, act urgently, even without consent, to avoid serious danger to the person's life or integrity*"[376].

In **France**, obstetricians and gynaecologists initially rejected the term "gynaecological and obstetric violence" and refused to join certain working groups on the subject[377]. In **the Netherlands**, healthcare professionals perceive the term 'obstetric violence' to be provocative and tend to react defensively to its invocation. Therefore, some choose to use the phrasing of the WHO 'disrespect and abuse' or 'mistreatment'[378].

In **Portugal**, the National Board of Physicians deems the term 'obstetric violence' to be inappropriate as it causes alarm and fear among pregnant women and calls into question health professionals who provide the best possible care according to the most recent scientific evidence[379]. Therefore, there was some opposition to the draft legislation aiming at criminalising obstetric violence, on the basis that some of the acts that would be considered as violent and therefore criminalized are medical acts.

In **Spain**, in June 2021, the Women's Institute, together with the Ministry of Equality, initiated a cycle of discussions for the amendment of law 2/2010. These discussions included a round table on "Proposals to eradicate obstetric violence from the health system"[380]. In July and August 2021, gynaecology and obstetrics associations issued different communiqués throughout Spain denying the existence of this problem and rejecting the use of the term "obstetric violence". The Spanish Society of Gynaecology and Obstetrics declared '*obstetric violence' as a legally criminal, morally inadequate and scientifically unacceptable concept*'[381]. The General Council of Medical Associations, a nationwide

(EBCOG), European Midwives Association (EMA). Joint position statement: Substandard and disrespectful care in labour - because words matter, Eur J Obstet Gynecol Reprod Biol 296, 2024, pp.205-07.

376 Di Lello Finuoli M., *Profili Penali della C.D. Violenza Ostetrica*, Sistema Penale, 2022. Available at: https://www.sistemapenale.it/it/articolo/di-lello-finuoli-profili-penali-violenza-ostetrica

377 Sauvegrain P, Schantz C. , Gaucher L., Chantry A. A., Avenues for Measuring and Characterising Violence in Perinatal Care to Improve Its Prevention: A Position Paper with a Proposal by the National College of French Midwive, Midwifery, October, 2022, https://www.sciencedirect.com/science/article/pii/S0266613822002716?via%3Dihub

378 Please see van der Van der Waal, R., Mayra, K., Horn, A. and Chadwick, R. (2022b) *Obstetric Violence: An Intersectional Refraction through Abolition Feminism*. Feminist Anthropology. https://doi.org/10.1002/fea2.12097, for a more thorough discussion on this problem with the terminology. In addition, there is a more context specific issue that has to do with the translation. In the Netherlands, the word '*verloskunde*' is the more common word for obstetrics, although a literal translation of obstetrics ('*obstetrie*') does exist. This is confusing, because '*verloskundige*' is also the newer gender-neutral term for midwife – '*vroedvrouw*' is the traditional word.

379 Ordem dos Medicos, Parecer do Colégio da Especialidade de Ginecologia e Obstetrícia da Ordem dos Médicos sobre o Projeto de Lei n.º 912.XIV PAN, 2021, https://ordemdosmedicos.pt/wp-content/uploads/2017/09/Parecer-Projeto-Lei-912XIV-2.pdf

380 Propuestas para erradicar la violencia obstétrica del sistema sanitario: https://www.youtube.com/watch?v=z185iKRJHrE

381 Sociedad Española de Ginecología y Obstetricia S.E.G.O., *Violencia obstétrica: Un concepto legalmente delictivo, moralmente inadecuado, científicamente inaceptable*, https://us18.campaign-archive.com/

organisation, publicly expressed its strong opposition to it[382]. In September and October 2021, the Ministry of Equality met with experts and activists, then with health professionals. Despite social and political pressure for the inclusion of 'obstetric violence' in the new legislation, the law was published in March 2023 without including the term, which was replaced by concepts such as "*appropriate gynaecological and obstetric interventions*" understood as "*those that promote and protect women's physical and psychological health within the framework of sexual and reproductive health care, in particular by avoiding unnecessary interventions*", and "*Violence against women in the reproductive field*" understood as "*Any act based on gender discrimination that violates the integrity or free choice of women in the area of sexual and reproductive health, their free decision on motherhood, its spacing and timing*"[383].

In 2018, a statement regarding the possible conflict of dissenting opinions in obstetric care was published by the **Finnish** Society of Obstetrics and Gynaecology, in conjunction with The Finnish Perinatological Society. The board of Finnish Society of Obstetrics and Gynaecology decided not to use the term "obstetric violence" in seminars with the rationale that this term implies intentionality. Yet, in November 2023, topics related to obstetric violence have been presented in seminars.

Research carried out in the 27 EU Member States show that overall, there is limited understanding of the phenomenon among healthcare professionals, which, together with a lack of official data, leads to the assumption that these cases are anecdotal. In several Member States, obstetricians and gynaecologists' organisations have issued statements questioning the accuracy of the reported numbers, such as in **Belgium**, where the Royal College of French-speaking obstetrician-gynaecologists opposed to the definition given to gynaecological and obstetric violence (in a publicly funded study) and questioned the accuracy of the figures reported in several studies. Others have pointed at the lack of data itself to minimise the need to adopt legal or policy response to the issue, such in **Portugal** where opposition to the new law mentioned that '*The need for the law n912/XIV/2.ª " (…) is not supported by the reality of providing obstetric health care in Portugal and the legal definition of obstetric violence must be refuted and, consequently, the proposed concepts of physical and psychological violence*"[384] (see also Box 5).

Research also points to the difficulties in acknowledging underlying power structures and unequal power relations between patients and healthcare professionals. In several countries, such as **Slovenia** or **Portugal**, professional organisations also highlighted the subjectivity of what can be considered physical or psychological 'violence': the pain women can feel during obstetric or gynaecological care (e.g. when giving birth) can be considered as 'normal' in certain circumstances. Thus, they fear that they could be considered as committing a crime by 'inflicting' or not stopping this pain. This fear of litigation is also pointed out as a potential deterrent for young health professionals from choosing gynaecology and obstetrics, in a context where those specialties already suffer from a lack of practitioners in many Member States[385].

7.1.2. Pushing for an alternative frame

As mentioned above, professional associations tend to resist framing the issue as 'violence'. However, it is important to note and to recognise that key professional organisations of obstetrics and gynaecologists at EU and international level consulted in the framework of this study do recognise the

[382] Organización Medica Colegial de España, El CGCOM rechaza el concepto de "violencia obstétrica" para describir las prácticas profesionales de asistencia al embarazo, parto y posparto en España, 2021, https://www.cgcom.es/noticias/el-cgcom-rechaza-el-concepto-de-violencia-obstetrica-para-describir-las-practicas

[383] Organic Law 1/2023, of 28 February (Ley Orgánica 1/2023, de 28 de febrero, por la que se modifica la Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo), https://www.boe.es/buscar/doc.php?id=BOE-A-2023-5364

[384] Ordem dos Medicos, Parecer do Colégio da Especialidade de Ginecologia e Obstetrícia da Ordem dos Médicos sobre o Projeto de Lei n.º 912.XIV PAN, 2021, https://ordemdosmedicos.pt/wp-content/uploads/2017/09/Parecer-Projeto-Lei-912XIV-2.pdf

[385] Interview with the European Board and College of Obstetrics and Gynaecology (EBCOG) Representative, February 2024.

existence of some issues in relation to obstetric and gynaecological care. However, they also point to the counter productive nature of using 'violence' to refer to acts that should be considered as individual malpractice. Therefore, they advocate for the use of a more terminology with more positive connotations, such as 'respectful care'.

Similarly, throughout Europe, we observe that professional organisations have been discussing issues in relation to obstetric and gynaecological care, but only few do so under the term 'violence'.

In some countries, there has been an active push to promote a counter discourse to the one promoted by civil society. The use of alternative terminologies has been observed in several Member States, where professional organisations have used and directly promoted the use of different concepts such as 'preventing the violation of patients' rights' (in Poland), 'dehumanised treatment' (Spain) 'well-treatment' (France), or 'providing good quality care' (Ireland), 'over-treatment' (Denmark).

In **France**, following the report from the High Council for Equality between women and men (see Section 5.2.2), the Academy of Medicine adopted a report in September 2018 entitled "On well-treatment in obstetrics – the reality of how maternity hospitals operate"[386]. The report, which provides an assessment of the evolution of obstetrics and maternity hospitals in France since the end of the 1970s, details all the developments that have impacted obstetric care, whether legislative, organisational or societal. Interestingly, although the report does not endorse the term 'obstetric violence', it does gather elements for its definition[387]. The authors note very positive progress in obstetric care over the past 30 years, but they also highlight the disparity of practices (including high prevalence of c-sections, induction, use of oxytocin during labour, instrumental extractions, episiotomies) – which sometimes go against clinical practice recommendations, and have an impact on women's psychological health (the report notes that defects in the quality of care could *"result in major psychological disturbances analogous to post-traumatic stress disorder (PTSD) which will require complex psychosomatic care. (…) which would affect nearly 5% of patient*s''). The report lists some recommendations to improve care provided to women. Although the report does not use the term 'violence', the analysis contributes to the objectification of the phenomenon of "obstetric violence" and the recommendations issued by the Academy constitute an additional element calling for a necessary evolution in the management of pregnancies and childbirths in France.

However, obstetric and gynaecological violence should not be assimilated to medical malpractice or negligence. It is a structural problem that needs to be addressed in a comprehensive manner, moving beyond contextual and logistic issues by showing how it impacts on women's human rights, equality, health and reproductive autonomy[388].

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386 Académie de médecine, Rapport 18/09, De la bientraitance en obstétrique ; la réalité du fonctionnement des maternités, bull. acad. Natle Med. 202, n°7, 2018, pp1323-1340, p. 1324,

387 According to this report, obstetric violence must be understood as "any medical act, posture, intervention that is inappropriate or non-consensual. It therefore covers not only acts that do not comply with clinical practice recommendations, but also medically justified acts carried out without prior information and/or without the consent of the patient or with apparent brutality. Finally, attitudes, behaviours and comments that do not respect the dignity, modesty and privacy of women are also cited under this term, as well as those resulting in the failure to consider [women's] pain during and after childbirth''

388 Amorim Melania M., da Silva Bastos M. H., Katz L., *Mistreatment During Childbirth*, Lancet 396 (10254), 816, 2020, https://www.sciencedirect.com/science/article/pii/S0140673620315634?via%3Dihub

Framing those systemic issues as violence contributes to making visible a hidden form of direct and structural gender-based violence and allows women to reclaim their reproductive life cycles from the dominant biomedical approach to reproductive health[389].

7.1.3. An emerging preoccupation among obstetric and gynaecological professionals

As seen above, overall, issues in relation to the provision of obstetric and gynaecological care are not ignored by healthcare professionals, and many do acknowledge the importance of addressing the issue. As mentioned in Section 4.4, in some countries, health professionals have been supporting women's demands to better recognise and acknowledge the existence of this form of violence.

Inside countries, there are also dissension between healthcare professional associations, such as in **Spain**, where not all health professional associations have adopted the same position towards obstetric and gynaecological violence. In contrast to the situation at state level and in other regions (autonomous communities[390]) that spoke out against recognising 'obstetric and gynaecological violence' (see Section 7.7.1), the Catalan Society of Obstetrics and Gynaecology and the Council of Medical Associations of Catalonia have recognised the term "obstetric violence". In December 2023, they have issued a statement showing their acceptance of the Plan proposed by the Health Department of Catalonia for the construction of more respectful care.

Box 12: Acknowledging obstetric and gynaecological violence – Catalan Society of Obstetrics and Gynaecology and the Council of Medical Associations of Catalonia

The Catalan Society of Obstetrics and Gynaecology and the Council of Medical Associations of Catalonia released a joint statement on obstetric violence[391], acknowledging that the term may cause discomfort to health professionals, but also highlighting its international recognition and adoption by organisations such as the United Nations and European Institutions. The statement considers that denying the existence of those issues can erode trust between women and professionals, which is essential for satisfactory results in pregnancy and childbirth processes.
"*Despite the discomfort that the term obstetric violence may generate, it has been internationally recognized and adopted by the United Nations and the European Commission, among other organisations and institutions. The Generalitat of Catalonia itself has regulated it and defined its meaning in Law 17/2020, of 22 December, amending Law 5/2008, on the right of women to eradicate male violence. It is therefore important to overcome the initial rejection of the term in order to grasp its real meaning and to be able to enter into the debate on the fundamental issues*"[392]. The statement points out that it is crucial to improve the education and training of professionals and society through constructive and proactive

[389] Pickles C., "Obstetric Violence," "Mistreatment," and "Disrespect and Abuse": Reflections on the Politics of Naming Violations During Facility-Based Childbirth, Hypatia, 38(3), 2023, pp.628-649, doi:10.1017/hyp.2023.73

[390] The Official College of Doctors of Zaragoza (COMZ), the Aragonese Association of Gynaecology and Obstetrics (AGOA), and the Aragonese Society of Contraception (SAA) have expressed their firm rejection of the term "obstetric violence". The same applies to the Andalusian Council of Medical Associations, the Official College of Doctors of Alicante or the Society of Obstetrics and Gynaecology of the Valencian Community

[391] Societat Catalana d'Obstetrícia i Ginecologia (SCOG) i el Consell de Col·legis de Metges de Catalunya (CCMC), Comunicat conjunt de la Societat Catalana d'Obstetrícia i Ginecologia (SCOG) i el Consell de Col·legis de Metges de Catalunya (CCMC) sobre la 'violència obstètrica', 2021, https://www.comb.cat/Upload/Documents/9/3/9315.PDF

[392] Ibid

debate. The Catalan Society of Obstetrics and Gynaecology and the Council of Medical Associations of Catalonia expressed their commitment to being an active part of this change by undertaking initiatives to disseminate information, raise awareness, and train professionals.
However, the statement also points to concerns about the possibility that the legal assimilation of obstetric violence with gender-based violence could imply the criminalisation of professionals under rules foreseen for intentional situations that are not specific to professional performance.

It is also important to note that midwives have generally been more ready to acknowledge the existence of obstetric (and, to a lesser extent, gynaecological) violence[393]. In many Member States, they are active in promoting a better understanding of those issues, fostering their recognition among medical professionals, and encouraging for the adoption of less medicalised care.

In **Lithuania**, the Association of Midwifes of Lithuania clearly and openly committed to combating obstetric violence. In **Germany**, the Midwives Working Group organised panels on obstetric violence during the two last national perinatal conferences, both in 2021 and 2023 (using the terms 'disrespectfulness', 'violence', 'respectful care' and 'good birth experience'). The German midwife association also regularly publishes statements on obstetric violence, usually during the occasion of the Roses Revolution[394]. In 2021, the **Catalan** Association of Midwives (**Spain**) published a position paper on obstetric violence[395] in which it stated that denying this type of gender-based violence distances professionals from reality and highlighted the need for associations to work together to improve sexual and reproductive care and support actions that review the quality of the services offered. **France**'s national college of midwives (CNSF) has published a commentary on the recognition of the term "violence" in the perinatal field, proposing a set of questions that could be used in conjunction with a national survey to quantify gynaecological and obstetric violence experienced by women in France[396]. In May 2024, the **Estonian** Association of Midwives have planned a conference on the topics of violence, among which obstetric violence will also be discussed.

In some countries, those organisations were also pioneers in denouncing the situation of the healthcare systems and the impact on care that women receive. In **France**, the National Council of the Order of Midwives has been denouncing obstetric violence for several years. According to the organisation, the issue is directly linked to the place given to patients, the (lack of) time healthcare professionals can allocate to each patient, and the quality of the dialogue between patients and caregivers[397]. The Order is also in favour of a law on women's health that would also address the issue of obstetric and gynaecological violence[398]. Similarly, in **Ireland**, the Irish Nurses and Midwives Organisation has not addressed obstetric violence but protested in 2014[399] to highlight the severe overcrowding in the emergency department, patients being deprived of care with dignity, and inadequate availability of beds throughout the hospital.

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393 However, it is important to note that midwives are less involved in gynaecological care, thus potentially less likely to denounce this form of violence.

394 DHV 2019, No violence on childbirth and DHV 2020 Violence-free childbirth as a mission.

395 Associacio Catalana de Llevadores, *Posicionament de l'ACL en resposta al comunicat emès per l'Organització Mèdica Col·legial d'Espanya*, 2021, https://www.llevadores.cat/activitats/activitats-acl/gestions-col-laboracions-acl/1752-posicionament-de-l-acl-en-resposta-al-comunicat-emes-per-l-organitzacio-medica-col-legial-d-espanya

396 Sauvegrain, P, Schantz C., L Gaucher, et AA Chantry, Avenues for Measuring and Characterising Violence in Perinatal Care to Improve Its Prevention: A Position Paper with a Proposal by the National College of French Midwives, Midwifery, October 2022, https://www.sciencedirect.com/science/article/pii/S0266613822002716?via%3Dihub

397 Ordre des Sages-Femmes, *Rapport sur les violences obstétricales : une nécessité*, 2017, https://www.ordre-sages-femmes.fr/actualites/rapport-sur-les-violences-obstetricales-une-necessite/

398 Ordre des Sages-Femmes, *Une proposition de loi pour la santé des femmes*, 2023, https://www.ordre-sages-femmes.fr/actualites/une-proposition-de-loi-pour-la-sante-des-femmes/

399 https://www.rte.ie/news/2014/1110/658202-naas-hospital/

7.2. Initiatives to improve awareness and understanding among medical professionals

Overall, in spite of limited policies to address the issues and controversies about the wording, the research has identified a number of initiatives and measures (sometimes developed by healthcare professionals themselves) to help healthcare professionals understand and prevent these issues across the Member States. Some of those developments have aimed at increasing awareness and improving responses to issues denounced by women and illustrate a greater concern among healthcare professionals to better understand the problem, and to reflect upon the relationship between patients and caregivers.

7.2.1. Awareness raising initiatives

In **Finland**, in the aftermath of the '#Minä Myös Synnyttäjänä' ('Me Too in the birthing room' see section 4.2), the Finnish Society of Obstetricians and Gynaecology organised a one-day event targeting obstetricians and gynaecologists, on 'Birth culture from a sociological viewpoint', addressing the transition started by the campaign and discussing the experiences of obstetric violence reported by women.

In **Luxembourg**, issues related to obstetric and gynaecological violence have been openly addressed and several midwives and obstetricians and gynaecologists are part of the scientific council who issued some recommendations on obstetric violence (including a definition) in 2021[400]. In **Portugal**, the National Association of the Students of Medicine has held events on obstetric violence, openly discussing the issue. In **Sweden**, the Swedish Society of Obstetrics and Gynaecology provides access to a lecture on Obstetric violence available for clinicians on its homepage[401]. This lecture was given during a webinar held in October 2023 and both obstetricians and midwives were invited to attend.

In **Cyprus**, where limited information has been found on obstetric and gynaecological violence, a conference that addressed the issue of obstetric violence presented the results of a prevalence study carried out in 2023 (see section 2). In addition to the study results, testimonies from women victims of obstetric violence were presented by the "Birth Forward" NGO. In **Greece**, during the 28th Pancyprian Conference of Nursing and Obstetrics that took place in 2021, one presentation was focussing on "Experiences of obstetric violence and perinatal support for pregnant women" in Greece[402].

7.2.2. Working groups

In some Member States, working groups have been set among professional organisations to reflect upon the issue and develop improved processes and working practices.

In **Spain, at regional level**, a working group for the study and prevention of obstetric violence (GtepVO) has been set up by the Catalan Society of Obstetrics and Gynaecology in Catalonia. It was created with the ethical commitment to work for the integral health of women, showing its willingness to gather and generate consensus regarding this reality. In addition, its aim was also to review obstetric violence in a multifaceted, open and unprejudiced way, deploying cross-cutting and multidisciplinary awareness-raising, training, research and prevention strategies. The different activities carried out include the promotion of the rights of users and patients of the health system; support for women

[400] Conseil Scientifique – Domaine de la Sante, *Les violences gynécologiques et obstétricales*, 2021, https://conseil-scientifique.public.lu/dam-assets/publications/sant%C3%A9-de-la-femme/violences-gynecologiques-et-obstetricales-valide.pdf

[401] Remaeus K., Obstetriskt Vald, 2023, https://www.sfog.se/media/338618/obstetriskt-vaald_perinatal-arg.pdf

[402] Antoniou, K., The experience of childbirth in public hospitals. An investigation of the phenomenon of obstetric violence in Greece. Masters' Thesis, Health Care Management, Hellenic Open University, 2021, https://apothesis.eap.gr/archive/item/92128

through the creation of different groups and meetings; development and dissemination (through social networks, talks, workshops and seminars) of materials aiming to raise awareness; and training and research aimed at improving the quality of health care services.

In **France**, the French Society of Perinatal Medicine (Société Française de Médecine Périnatale – SFMP) launched a working group on well-treatment at the end of 2022. The group is made up of obstetricians, anaesthetists, paediatricians, representatives of patient associations and midwives. It aims at providing an opportunity to retrace the history of women's demands relating to obstetric violence, and to develop recommendations in a report that should be published in October 2024.

Other local initiatives have been identified in **France at regional level**, with the work carried out by the Study Circle of Obstetrician-Gynaecologists of Île-de-France (Cegorif) to openly reflect upon obstetrician-gynaecologists' involvement in this violence and how they could mitigate it, or even prevent it. Cegorif created a working group on well-treatment in obstetrics and gynaecology, with obstetricians, midwives, paediatricians and anaesthetists from the various maternity hospitals in Ile-de-France (Paris and surroundings)[403]. Representatives from specialised associations (such as CIANE[404]) also participated, and discussions allowed healthcare professionals to better understand the impact of the absence of dialogue between doctors and patients, on the basis of testimonies from women. In 2018, Cegorif worked together with a women's rights organisation (Maison des femmes de Saint-Denis[405]) to create a "Well-treatment/Benevolence Club" (*Club Bienveillance*) that initiated a reflection on their practices and offered educational tools for patients and professionals. The club has developed three short films each dealing with specific issues in relation to obstetric and gynaecological care (including a woman's request to have an abortion; the provision of emergency care after a miscarriage; and a pregnancy consultation followed by childbirth). These communication products aimed at opening dialogue between patients and caregivers to better understand patients' expectations and the difficulties that can arise in certain situations, and at improving healthcare practices during those[406].

7.2.3. Training

a. Limited integration of those issues in regular curriculum of healthcare professionals

The research has also identified a few examples of standardised and systematic training that is part of the curricula of medical students, albeit in a limited number of countries.

In **France** where in certain universities, training on consent and obstetric and gynaecological violence seems to be covered during the first cycle of medical studies. However, the programmes depend on the universities, each faculty having the freedom to address these questions when it wishes and as it wishes. In Strasbourg, for example, third-year students take courses in forensic medicine on domestic and sexual violence, including obstetric and gynaecological violence. A university diploma called 'Treatment of violence against women, towards well-treatment' aiming to train caregivers on the medical consequences of violence against women, that also includes a module on care-related violence ('les violences du soin') has been delivered in two French universities (Paris-Cité (formerly

[403] Hatem-Gantzer Ghada, Violences obstétricales et gynécologiques. L'expérience du Cercle d'études des gynécologues obstétriciens d'Île-de-France (Cegorif), Périnatalité, 2020/4 (Vol.12), 2020, pp. 178-182., https://www.cairn.info/revue-perinatalite-2020-4-page-178.htm

[404] Inter-associative collective around birth, https://ciane.net/

[405] Maison des femmes de Saint-Denis

[406] https://temoignages-violences-obstetricales.fr/documentaire-violences-obstetricales-gyneco/

Descartes) and Grenoble) since 2017. To date, 250 caregivers (half of whom are doctors)[407] undertook this training.

Additional examples of standardised training focusing more specifically on obstetric violence have been identified in other Member States, such as in **Austria**, where the topic of obstetric violence has appeared more frequently in training courses for midwives in recent years, and initial training courses for doctors are also taking place. In **Luxembourg**, the theme of the 2019 annual training taking place at the Bohler Clinic, to which all the gynaecologists and midwives of the country are invited, was well-treatment during care, with a presentation on "Daily Well-treatment – when taking care is not the same as providing care – Ethical vigilance"[408]. In **the Netherlands**, there have been several training initiatives on obstetric violence targeting midwives. In **Germany**, there is no systematic training offered to healthcare professionals, but according to IMAgiNE EURO those professionals themselves call for more training in respectful maternity care.

b. Training carried out in collaboration with CSOs

Training has also been organised to improve understanding and awareness. Most trainings have been initiated by civil society organisations or research institutions.

Box 13: Training initiatives for healthcare professionals in Croatia

In Croatia, after the first wave of #break the silence (PrekinimoŠutnju) in 2014, part of the government response was to run a pilot programme of the Mother Friendly Hospital (MFH) Initiative[409]. As part of this initiative, a baseline assessment was carried out, followed by a training and assessment six months later.

The initial training took place in 2015 and was based on human rights mechanisms as they relate to women's health and care in sexual, reproductive and maternity services, prepared for a health service provider perspective. The training was based on the ten steps for Mother-Friendly Hospitals

The event was held at the Ministry of Health, planned as a train-the-trainers event, with representatives from the four hospitals piloting the MFH Initiative who were then supposed to run the training at their own hospitals. The team of representatives from each hospital included two of each of the following healthcare professionals: obstetrician-gynaecologists, midwives, neonatologists and neonatal nurses, as well as two members of ward / department management.

Despite calls from civil society (in 2015[410] and again in 2019[411]) no further trainings were conducted due to a government change and lack of political will. The results from the baseline assessment and post-training assessment were never made publicly available, but information gathered showed that there was little or no change.

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407 https://unmaillonmanquant.org/formation-universitaire/#1525184309389-d3d09d4c-2f1f; https://unmaillonmanquant.org/wp-content/uploads/2019/05/Plaquette-Diu-19-20-BATc.pdf

408 Hopitaux Schuman, *Journée d'étude bientraitance*, 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10084060/

409 Rodalista, *Initiative: Pilot program Rodilišta prijatelji majki i djece u RH* | Rodilišta (roda.hr)*:: 10 koraka za Rodilišta prijatelji majki i djece* | Rodilišta (roda.hr), https://rodilista.roda.hr/rodilista-prijatelji-majki/pilot-program-rodilista-prijatelji-majki-i-djece-u-rh.html

410 https://www.roda.hr/udruga/programi/trudnoca-i-porod/godinu-dana-nakon-akcije-prekinimo-sutnju.html

411 https://www.roda.hr/udruga/projekti/prekinimo-sutnju/godinu-dana-nakon-prekinimosutnju-a-vlada-i-dalje-suti.html

Nowadays, Roda (see Section 4.1) is currently running a CERV project[412] with a training component for health providers planned as part of the activities in the next 24 months. There are two free online courses available to women, that healthcare workers could potentially take as well, although there is no data available on their uptake: Your Rights in Pregnancy and Childbirth[413] and Empowered in the health system[414].

The Portuguese Association for Women' Rights in Pregnancy and Childbirth[415] provides a training for health professionals about women's rights, but most of trainees are nurses and doctors. In **Estonia**, in 2019, the training "Violence in obstetrics and human rights-based approaches to sexual and reproductive health" was organised by Estonian Sexual Health Association[416].

In **Belgium**, the Citizen Platform for a Respected Birth in partnership with Henallux Fors[417] held a training aiming to help healthcare professionals understand and identify lack of respect and abuse in the context of perinatal care, and to provide them with tools to prevent or act when these situations arise. This initiative was financed by the Walloon and Brussels Regions as well as by the Wallonia-Brussels Federation. It was part of projects funded under the intra-Francophone plan to combat violence against women mentioned in Section 5.2.2.

In **the Netherlands**, the two important independent organisations—Birth movement (Geboortebeweging) and the Foundation for Birth Trauma (Stichting Bevallingstrauma[418])—working on obstetric violence teach classes in midwifery schools and on request on care outside of regular guidelines and respectful maternity care, in which the term obstetric violence is also mentioned.

In **Poland**, in 2004, the Childbirth with Dignity Foundation published a guide on observing patient rights and examples of good practices for medical staff and provide training to healthcare professionals[419].

c. Small-scale initiatives at local level

Interesting examples of small-scale initiatives implemented in some cities, or some healthcare facilities have also been identified, such as in **Austria** where some hospitals like the maternity department of the hospital in Ottakring, in Vienna, are working on improving the way feedback from patients having just given birth is collected (through '*birth debriefings*') and the rapid response to potential experiences of violence. In-house training for hospital managers has also recently started to be organised at regional level.

412 https://www.roda.hr/en/projects/respect/

413 https://edukacija.roda.hr/tecajevi/za-roditelje/tvoja-prava-u-trudnoci-i-porodu/

414 https://edukacija.roda.hr/tecajevi/za-roditelje/osnazene-u-zdravstvenom-sustavu/

415 https://associacaogravidezeparto.pt/

416 https://seksuaaltervis.ee/

417 https://www.henallux.be/les-formations

418 https://stichtingbevallingstrauma.nl/

419 Fundacja Rodzic po Ludzku, Jak przestrzegać praw pacjenta? Przykłady dobrych praktyk. Wskazówki dla personelu oddziałów ginekologicznych, patologii ciąży i położniczych, 2010, https://rodzicpoludzku.pl/publikacje/jak-przestrzegac-praw-pacjenta-przyklady-dobrych-praktyk/

In **Lithuania**, clinics regularly organise professional skills training in simulation classes and psychological trainings on how to manage stress or empathetically communicate with patients however, the focus is on improving communication rather than addressing violence.

The American Hospital of Paris, in **France**, launched a training seminar in 2022[420] to teach the importance of respectful maternity care in French hospitals. Its aim is to promote best practices in respectful maternity care and fight against all forms of obstetrical and gynaecological violence. Offered free of charge to all healthcare professionals involved in maternity care throughout France, the seminar has already been attended by more than 150 gynaecologists, midwives, nurses, paediatric nurses and nurses' aides from a number of French maternity units.

In **Spain**, the Universitat Jaume I (Valencian Community) has organised congresses, workshops and seminars on obstetric violence since 2019[421]. In 2021, the Germans Trias I Pujol Hospital organised a conference on obstetric violence in collaboration with different entities[422] and has been a pioneer in promoting the constitution of a multidisciplinary Commission for the Prevention of Obstetric Violence. Vall d'Hebron University Hospital (in Barcelona, Catalonia) has also created a Zero Obstetric Violence Subcommittee.

In **Finland**, training courses have been organised in several hospitals and maternity clinics across the country, on 'Birth culture in transition and improving birth experiences', addressing the findings emerging from the awareness campaign on obstetric violence and discussing how to transition toward better care. The targets of those training courses were obstetricians and midwives and public health nurses[423].

d. Training for non-medical professionals

Interestingly, some training has also targeted other groups of stakeholders to address misunderstanding and resistance to the phenomenon. This is the case in Portugal, where despite the lack of 'legal classification' of obstetric and gynaecological violence (see Section 2), there seems to be some wider reflexion on how to legally respond to the issue and provide women with adequate legal support. A training course addressing legal issues related to obstetric violence targets legal professionals (and uses the terminology 'violence').

Box 14: Training for legal professionals in Portugal

The Portuguese Association for Women' Rights in Pregnancy and Childbirth (see A1.3) organised training courses on women's rights in pregnancy and childbirth.

The aim of these training sessions was for forensic professionals to act in accordance with the legal framework in force, basing the exercise of their professional activity on respect for the human rights of pregnant women, women who have recently given birth and women in labour. Another training was carried out at the Legal and Judicial Training Unit (UNIFOJ), the training unit of the Permanent Observatory of Justice (OPJ) of the Centre for Social Studies (CES) of the University of Coimbra, in 2021 and 2022.

In 2023, the Association for the Rights of Women in Pregnancy and Childbirth and Vania Simões, a legal expert, also organised several trainings addressing legal issues in relation to obstetric and

[420] https://www.american-hospital.org/en/support-us/projects/respectful-maternity-care-marks-one-year-milestone

[421] The Society of Obstetrics and Gynaecology of the Valencian Community put pressure on the Rector of the aforementioned university requesting the withdrawal of its endorsement and the suspension of the activities organised, see https://www.sogcv.com/archivos/Carta_Rectora_UJI_Violencia_Obstetrica.pdf

[422] *Programa de las II Jornadas de Salud Mental Perinatal*, https://www.sociedadmarce.org/IMAGES_35/violenciaobstetrica.pdf

[423] The training took place in 6 hospitals around the country (and some maternity clinics), including: Mikkeli Hospital, Satasairaala, Länsi-Pohja, Seinäjoki, Kokkola, Oulu, and Lahti

gynaecological violence to train judges. This initiative responds to a demand from legal professionals, including students and researchers. The training was developed by experts from the Association for Women's Rights in Pregnancy and Childbirth (including lawyers, sociologists, nurses, doulas and psychologists).

In March 2024, an online training developed in collaboration between the Portuguese Association for Women's Rights in Pregnancy and Childbirth and the Bar Association targeted legal professionals to support women at the Portuguese Association for the Support of the Victim (APAV).

7.3. Emerging initiatives to improve obstetric and gynaecologic care

7.3.1. Improving practices towards evidence-based care

Guidelines and codes of conduct for health professionals have been developed by professional organisations to promote good practices in obstetric and gynaecological care (some directly mentioning the issue of obstetric or gynaecological violence). The content of those documents often make reference to the different WHO recommendations[424] and guidelines[425] and call for better alignment with those.

In **France**, the National College of Gynaecologists and Obstetricians of France (CNGOF) adopted a "charter of good gynaecological practices" in October 2021[426]. It also set up a Commission Promotion of Well-treatment in maternity wards (*Promotion de Bientraitance dans les maternités*) (PROBITE) in 2017, which brought together perinatal professionals and associations of patients and birth users, with one objective: to make well-treatment in maternity a priority. The ProBité working group wanted to reflect upon changing perinatal practices (through initial and continuing training of professionals, communication with parents, the recovery and analysis of poorly experienced births, etc.) However, the associations who were part of the working group were critical of its objectives and ended up leaving, and the commission therefore disappeared[427].

In 2023, new recommendations for the clinical practice of pelvic examination as well as a charter for care in the birthing room were presented during the CNGOF annual congress that gathered gynaecologists and obstetricians[428].

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424 WHO, Recommendations on antenatal care for a positive pregnancy experience, Geneva: World Health Organization, 2016, https://www.who.int/publications/i/item/9789241549912; WHO, Recommendations: intrapartum care for a positive childbirth experience, Geneva: World Health Organization, 2018, https://www.who.int/publications/i/item/9789241550215

425 WHO, Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers, Geneva: World Health Organization, 2017, https://iris.who.int/bitstream/handle/10665/259489/9789241513005-eng.pdf?sequence=1&isAllowed=y

426 CNGOF, Charte de la consultation en gynécologie ou en obstétrique, 2021 https://cngof.fr/app/uploads/2022/12/Charte-de-consultation-en-gynecologie-et-obstetrique.pdf?x13417

427 Association Nationale des Sages-Femmes Liberales, 'Du label et de la Probite', 2019. Available at: https://ansfl.org/infos/du-label-et-de-la-probite

428 https://profession-sage-femme.com/examen-pelvien-des-rpc-pour-rassurer/

In **Germany**, high evidence-based guidelines for vaginal birth at term were published in December 2020 (part 1[429] and part 2[430]) to establish best-practice standards. They underline national law on respectful care. However, the guidelines are not legally binding and are not implemented at national level, partly due to lack of staff.

Labels/awards for healthcare facilities promoting good practices in obstetric and gynaecological care have been promoted in a few Member States. In **France**, the Quality label for maternity care (launched by the National College of Gynaecologists and Obstetricians of France) is a certification attributed to maternity wards/hospitals that are committed to putting the well-treatment of women at the centre of their concerns. They have to commit to transparency, quality of information and consent, improvement of medical practices that are always appropriate and in accordance with the most recent scientific recommendations. Patients can provide their feedback via an online platform called 'Maternys'[431,432]. However, this label was criticised by patient associations and midwives, as it was presenting as 'good practices' practices that should be the norm. It has also been mentioned that such label could be used to relieve hospitals/practitioners from their responsibilities and was developed without properly consulting associations and patients' groups[433,434,435]. Sixty maternity wards have obtained the label in 2023 (out of 360).

Some healthcare facilities also adopted commitments to address the issue. Such examples have been identified in **France**, where some hospitals seem to recognise the issue (some using 'violence' terminology, like Strasbourg hospital, which is committed to prevent obstetric and gynaecological violence, or Lyon, with the development and dissemination of a charter for consultation in gynaecology and obstetrics[436]), or in **Belgium**, where some hospitals have developed guidelines and commitments to respectful care, such as Obstetric well-treatment charters[437].

Box 15: Case Study: The standard of perinatal care in Poland

The In Poland, the standard of perinatal care, in force since January 2019, is normative and part of the Polish legal order. While not specific to obstetric and gynaecological violence, the standard sets out guidelines for the organisation of care that should be provided to a woman in the hospital during pregnancy, physiological labour, the postpartum period and during her care of the newborn. The

[429] Abou-Dakn M, Schäfers R, Peterwerth N, Asmushen K, Bässler-Weber S, Boes U, Bosch A, Ehm D, Fischer T, Greening M, Hartmann K, Heller G, Kapp C, von Kaisenberg C, Kayer B, Kranke P, Lawrenz B, Louwen F, Loytved C, Lütje W, Mattern E, Nielsen R, Reister F, Schlösser R, Schwarz C, Stephan V, Kalberer BS, Valet A, Wenk M, Kehl S., *Vaginal Birth at Term - Part 1. Guideline of the DGGG, OEGGG and SGGG* (S3-Level, AWMF Registry No. 015/083, December 2020). Geburtshilfe Frauenheilkd. 2022 Nov 3;82(11):1143-1193. doi: 10.1055/a-1904-6546. PMID: 36339636; PMCID: PMC9633231.

[430] Abou-Dakn M, Schäfers R, Peterwerth N, Asmushen K, Bässler-Weber S, Boes U, Bosch A, Ehm D, Fischer T, Greening M, Hartmann K, Heller G, Kapp C, von Kaisenberg C, Kayer B, Kranke P, Lawrenz B, Louwen F, Loytved C, Lütje W, Mattern E, Nielsen R, Reister F, Schlösser R, Schwarz C, Stephan V, Kalberer BS, Valet A, Wenk M, Kehl S. *Vaginal Birth at Term - Part 2. Guideline of the DGGG, OEGGG and SGGG* (S3-Level, AWMF Registry No. 015/083, December 2020). Geburtshilfe Frauenheilkd. 2022 Nov 3;82(11):1194-1248. doi: 10.1055/a-1904-6769. PMID: 36339632; PMCID: PMC9633230.

[431] College National des Gynecologues et Obstetriciens Francais, *Dossier de Presse: Gynecologie-Obstetriques – La parole aux femmes, Ecoute-Information-Evaluation-Partage*, 2019, http://www.cngof.net/Medias-CNGOF/Communiques/2019/CNGOF-dossier-presse-bientraitance-label-ressources-humaines.pdf

[432] Maternys, *Le Label CNGOF-MATERNYS – 2023: le label evolue*, https://www.maternys.com/label-cngof-maternys/

[433] Association Nationale des Sages-Femmes Liberales, *Du label et de la Probite'*, 2019, https://ansfl.org/infos/du-label-et-de-la-probite

[434] Collectif Interassociatif autour de la Naissance, Communique de presse – *Label du CNGOF: vous avez dit bientraitance?*, 2019, https://ciane.net/wordpress/wp-content/uploads/2019/10/CP-label-Bientraitance.pdf

[435] Institut de Recherche & d'Actions pour la Sante des Femmes, *Le Label du CNGOF et Maternys: des outils realises sans les associations de victims et d'usageres*, 2019, https://www.xn--violences-obsttricales-gyncologiques-ogdm.org/label-cngof-maternys/

[436] CHU Lyon, *Une charte de la consultation en gynécologies et en obstétrique*, https://www.chu-lyon.fr/une-charte-de-la-consultation-en-gynecologie-et-en-obstetrique

[437] CHU de Liège, https://www.chuliege.be/jcms/c2_23983670/gynecologie-obstetrique/bientraitance-obstetricale

standard obliges medical personnel to respect the right to informed participation in decisions related to pregnancy, labour, puerperium and the care of the newborn, including the scope of actions taken and medical procedures used; to treat the woman with respect, respect the privacy of the parturient and her sense of intimacy, and always obtain the consent of the parturient or her legal representative for the performance of procedures and examinations.

Public consultations were held on the draft regulation of the Minister of Health on the organisational standard of perinatal care. As many as 69 organisations, institutions, facilities and citizens submitted comments on it. The Childbirth with Dignity Foundation (see A1.3) presented the results of the report based on "women's voices", highlighting that the standard is largely consistent with WHO guidelines. Following initial resistance, the standards were slowly implemented and after some time, they were positively perceived not only by women themselves, but also by the staff of maternity hospitals.

Despite the normative nature of the organisational standard for perinatal care, many of its provisions are still far from being fully implemented. There is no provision for penalties to be imposed on a hospital that does not follow the guidelines from the standard. There are also no concrete ways of enforcing this regulation in practice. In spite of demands made by both the Supreme Audit Office and the Childbirth with Dignity Foundation to introduce regular monitoring and inspection of facilities to ensure compliance with the standard, no effect was achieved on the part of the Ministry.

However, while there were many facilities that did not meet all the quality-of-care conditions set by the standard, reports over the years by Childbirth with Dignity Foundation show improved quality of care. The inadequacies in the implementation of the standard are currently being addressed at several levels. Issues concerning the care of particularly vulnerable women, which can lead to discrimination and increase the risk of inequalities in access to quality maternity care, are unfortunately not addressed in the standard yet.

While not without flaws, by setting guidelines for health care facilities, the standard can be considered a step forward towards the prevention of obstetric and gynaecological violence.

7.3.2. Promoting alternatives to over-medicalisation of obstetric and gynaecological care

There are models of obstetric and gynaecological care that can meet the needs of both women and carers, and whose effectiveness has been scientifically evaluated. Research has shown that continuous support during labour may improve outcomes for women and infants, including increased spontaneous vaginal birth/decreased caesarean birth and instrumental vaginal birth, shorter duration of labour, limited use of any analgesia, use of regional analgesia, low five-minute Apgar score and negative feelings about childbirth experiences[438] . In several Member States, midwives and women have been campaigning for several years to be able to provide one -to-one care, which is a model of care that protects women and restores meaning to the profession of many midwives, who can then practice their art in satisfactory conditions.

In **Ireland**, the Irish Nurses and Midwives Organisation calls for women-centred maternity services, health orientated, and rooted in a social model of care where women can be active participants in

[438] Bohren M-A., Hofmeyr G-J., Sakala, Fukuzawa R.K., Cuthbert A., *Continuous support for women during childbirth*, Cochrane Database of Systematic Reviews, Cochrane Pregnancy and Childbirth Group (2017), https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003766.pub6/full

decisions that affect the care they and their babies receive. Research has shown that an important aspect of implementing evidence-based maternity care is to expand midwifery services and improve women's access to them. Midwifery units provide care based on the bio-psycho-social model of care. The Midwifery Unit Network (MUNet) and the European Midwives Association (EMA) work together to influence the implementation of maternity policies relating to safety, the health of women and their babies, and access to evidence-based maternity care[439]**.** Midwifery units aim to promote women's sense of autonomy, active promotion of health and well-being, and protection from harm. These aims are encompassed by the two key concepts of salutogenesis[440] and safety[441]. In 2018, there were 160 midwifery units in the UK, 120 in Germany, 26 in Switzerland and eight in France[442].

The research confirmed that one of the main issues in relation to obstetrics and gynaecology is that women with a low obstetrical risk are often subjected to unnecessary medical interventions when they give birth in facilities with a high level of medicalisation[443]. This has an iatrogenic effect on their mental and physical health, and often does not meet their wishes. Women with a low obstetrical risk who wish to do so should be allowed to give birth safely in places that are not over-medicalised.

Diversifying delivery structures would make it possible to better respond to the principle of women's autonomy, to offer them a real choice, and would contribute to reducing medicalization and automated procedures of care which dehumanize and expose them to increased risk of violence. In some countries (such as Belgium or the Netherlands), steps have been taken to diversify birthing facilities and encourage the implementation of midwifery-led birthing centres. In Belgium, for instance, the midwife-run programme 'le Cocon' (*the cocoon*) of the Erasme Hospital in Brussels enables pregnant women to give birth in a reduced medicalised environment, while also ensuring their safety and direct access to the operating room in case of unexpected complications during delivery[444]. Research carried out on those facilities showed that the physical and emotional safety of women and their families is respected, with a very low intervention rate.

It is also worth mentioning the progressive development of "low obstetric risk" areas in **Italy** ("aree a basso rischio ostetrico" – BRO areas) in a limited number of healthcare facilities[445]. BRO areas are meant

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439 Midwifery Unit Network: midwifery unit standards, 2018, https://www.midwiferyunitnetwork.org/download/munet-midwifery-unit-standards/

440 Salutogenesis refers to a scholarly orientation focusing attention on the study of the origins of health and assets for health, contra the origins of disease and risk factors, see: https://www.ncbi.nlm.nih.gov/books/NBK435854/ (Following Chantry et all, salutogenesis could be defined as a preventive care aimed at strengthening patient's health and limiting interventions and their associated iatrogenicity, to keep women in low obstetric risk) see Chantry, A., P. Sauvegrain, I. Roelens, C. Guiget-Auclair, S. Goyet, et F. Vendittelli. *Rapport d'étude sur la qualité des soins prodigués en maisons de naissance. Analyse des données 2018 par le groupe de recherche sur les maisons de naissance*, 2019, https://uca.hal.science/hal-04423634v1/document

441 Downe Soo., *Towards Salutogenic Birth in the 21st Century*. In Essential Midwifery Practice: Intrapartum Care, édité par Denis Walsh et Soo Downe, Blackwell Publishing Ltd, United Kingdom, 2010, pp. 289-96. United Kingdom.

442 Chantry, A., P. Sauvegrain, I. Roelens, C. Guiget-Auclair, S. Goyet, et F. Vendittelli, Rapport d'étude sur la qualité des soins prodigués en maisons de naissance. Analyse des données 2018 par le groupe de recherche sur les maisons de naissance, 2019.

443 Miller S, Abalos E, Chamillard M, Ciapponi A, Colaci D, Comandé D, Diaz V, Geller S, Hanson C, Langer A, Manuelli V, Millar K, Morhason-Bello I, Castro CP, Pileggi VN, Robinson N, Skaer M, Souza JP, Vogel JP, Althabe F., *Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide*, Lancet. 2016 Oct 29;388(10056):2176-2192, https://www.sciencedirect.com/science/article/pii/S0140673616314726

444 https://www.erasme.be/fr/problematiques-de-sante/le-cocon

445 Ministry of Health - National Birth Path Committee, Linee di indirizzo per la definizione e l'organizzazione dell'assistenza in autonomia da parte delle ostetriche alle gravidanze a basso rischio ostetrico (BRO) (Guidelines for the definition and

to limit medical intervention in low-risk pregnancies, thus supporting physiological and less medicalised deliveries. Such areas are entirely managed by midwives and subject to a number of additional obligations, including periodical training, common checklists to assess and regularly re-assess the level of risk of the mother and of the newborn, and clinical audits. Where such BRO areas exist, the number of medical interventions such as c-sections, episiotomies and perineal tears largely decreased in favour of non-medicalised or limitedly medicalised deliveries.

7.3.3. Initiatives to address specific needs and inclusive care

In a few Member States, some initiatives have been taken to adopt intersectional lenses and provide more inclusive obstetric and gynaecological care to specific groups of women.

a. **Migrant women**

As explored above (see Section 3.5), migrant women are among the groups more at risk of experiencing this form of violence. In Some Member States, the specificities of their situation (and added vulnerability) during obstetric and gynaecological care have been recognised. Some interesting initiative has been identified in Poland, where the Childbirth with Dignity Foundation and the Polish Migration Formula Foundation provided perinatal support to migrant and refugee women[446]. Another interesting initiative to respond to migrant women's specific needs has been identified in Sweden.

Box 16: Acknowledging additional barriers experienced by migrant women to access obstetric and gynaecological care in Sweden: Publicly funded Doulas

In Gothenburg (Sweden's second largest city) and the Region of Västra Götaland, a local CSO has been offering targeted support to non-Swedish speaking pregnant migrant women since 2008, thanks to the funding received by the local public health committee. Women may be accompanied by a 'cultural doula' as support and as interpreter during the delivery[447]. What was initially thought as a one-time grant from the local public health committee became a yearly contract with funding for the doula project[448] .

Throughout the year, this contract has been awarded to different CSO and since 2020, this publicly funded initiative is provided by the organisation 'Tidigt föräldrastöd'.

The service includes one to two visits during pregnancy to build a relationship between the doula and the woman. The Doula also provides support at the hospital during labour and remains with the woman until after the birth, typically the first two hours to help with initial breastfeeding and to provide support. This is followed by a home visit by the doula within the first week.

Primiparas and women newly arrived in the country are prioritised. However, if a woman is considered being in a vulnerable situation (e.g. survivor of intimate partner violence), exceptions are made for her to have access to this service repeatedly.

Women can access the services through two different routes: 1) her midwife refers her to the service, or 2) direct contact with the cultural doula (normally through word of mouth). Since all midwives are aware of the initiative, most, if not all, pregnant women in need are made aware of the service that is completely free of charge.

To provide support to the women, the doulas are trained on the Swedish health care system, patient rights etc. They also make sure that they understand the specific terms in Swedish and know how to

organisation of self-care by midwives in low-risk pregnancies (BRO)), https://www.salute.gov.it/imgs/C_17_pubblicazioni_2836_allegato.pdf.

446 https://forummigracyjne.org/projekt/wsparcie-integracji-cudzoziemcow-na-mazowszu

447 https://www.doulakulturtolk.se/goteborg/

448 Answers based on interview with chairwoman of the non-profit organization "Tidigt föräldrastöd" Bodil Frey, conducted in the framework of this research.

translate this into their own language (and the one of the women they assist). The service matches doulas and women sharing the same cultural background. However, in case this is not possible, additional time is provided before the birth for the doula and the woman to meet and share information of the woman's cultural norms. In c-section procedures, only one person is usually allowed to accompany the woman (the other parent). However, cultural doulas act as interpreters as well as doulas, so they are normally invited in addition to the partner being present.

At the start of the initiative, around 150 women per year benefited from this doula support. In 2023, increased funding enabled reaching out to 300 women yearly.

Similar initiatives have been replicated in other cities and regions of Sweden. In Umeå (region Västerbotten), the programme has been run by the region itself in 2015 and led by midwife Maria Österberg. In region Uppsala, approximatively 100 women per year receive information and training from cultural doulas before and after they give birth (the doula does not support during birth) since 2018. In Region Värmland (Karlstad) the service has been provided since 2014. It was originally run by the region itself (in a similar way to region Västerbotten) until 2022, but recently, the service is provided by a CSO, and a reduced number of women can access support. In Stockholm support is given to women by a non-profit organisation similarly to what is done in Gothenburg (however, the CSO receives about 1,000 request per year and can only provide support to 700 women). The initiative started in Södertälje in 2016, but later spread to the whole region in the spring of 2018. A doula initiative was also implemented in Region Halland but stopped due to insufficient funding. Similarly, a lack of funding did not enable Region Skåne to implement the initiative[449].

b. Initiatives aiming at improving specific groups of women's access to gynaecological care

Research has shown that some groups of women (and girls) face more difficulties to access gynaecological care and are more at risk of experiencing gynaecological violence (see Section 3.5). In several EU Member States, initiatives have been implemented to improve their access to care by monitoring and developing lists of healthcare professionals who provide more inclusive care. In **Poland**, a foundation working with women with disabilities has created a search engine for friendly gynaecological offices[450]. Similarly, the collaborative site "Go to Gyneco" is the first in **Belgium** to offer a space for discussion for the lesbian community and to recommend lesbian friendly professionals[451]. Interestingly, this initiative received funding in the framework of the call for projects launched under the implementation plan of the Intra-Francophone Plan to fight violence against women 2020-2024 (see Section 5.2.2). In **France**, a project has also been set up to develop a list of caregivers practicing gynaecological procedures with a feminist approach[452].

[449] See Sweden case study for additional information.

[450] Znajdź gabinet właściwy dla Ciebie, https://dostepnaginekologia.pl/

[451] Go to GYNECO!. https://gotogyneco.be/

[452] GYN&CO, https://gynandco.wordpress.com/trouver-une-soignante-2/trouver-une-soignante/

8. CONCLUSIONS AND RECOMMENDATIONS

8.1. Conclusions

Obstetric and gynaecological violence lies at the intersection of unequal gender relations (including the historically constructed medical control over women's bodies) and unequal power relations between patients and healthcare professionals. Demands concerning this issue are therefore at the crossroads of feminist struggles and struggles for respect for patient" rights.

Based upon existing studies, articles and initiatives identified at Member State level, the study has tried to provide an overview of the different manifestations and forms of violence comprised under the concept of obstetric and gynaecological violence—a concept that despite having gained prominence over the past 20 years, and having been recently put on the policy agenda in the European Union, still remains difficult to frame and to define.

In spite of the increasing amount of research and initiatives addressing the issues, the lack of a commonly agreed definition has severe consequences, including making the concept difficult to be operationalised in policies and programmes aiming at preventing the issue and enabling women access to redress mechanisms. In addition to issues with terminology, the lack of harmonised data at EU level but also within Member States themselves means that it is difficult to assess the prevalence of the problem and its manifestations.

No Member State has so far legally recognised obstetric and gynaecological as a form of gender-based violence and regulated it. The applicable legal framework in the Member States, whether derived from legislative provisions and/or constitutional norms and principles on patient rights, non-discrimination, gender-based violence/violence against women or from criminal law, does not appear to be effective in ensuring women get actual access to justice and redress.

The lack of legal recognition of this form of violence mirrors the lack of societal awareness on what obstetric and gynaecological violence is. Stereotypes, sexism, condescension and paternalism are still widespread in relation to women, particularly when pregnant, in both healthcare and courts. On top of that, the budgetary restrictions of healthcare systems hinder the practice of respectful care. As a consequence, women's rights as patients are not always respected, and complaints are not filed, because of the perception that they are not victims, their fear of re-victimisation, the perception that they lack chances of winning, costs of redress (particularly in judicial cases), and the difficulty of finding a lawyer specialised in the issue.

Yet, over the past years, the concept has gained traction thanks to numerous awareness raising initiatives initiated by civil society organisations, or to campaigns that have flourished through social networks to collect women's experience of obstetric and gynaecological violence. Those initiatives have helped women identify anomalous or even traumatic experiences as violence, and in the majority of Member States, women might rely on the support provided by civil society organisations to better understand their rights and access redress mechanisms. In addition, those initiatives have made a substantial contribution to place the issue on the societal agenda and to call for improved legal and policy responses.

As a result, Member State legal and policy (national and regional) frameworks have started to acknowledge the issues (but not always framing the issue under 'violence'). Examples include Belgium, France, Germany, Luxembourg, or Spain.

Those demands for better recognition and prevention of obstetric and gynaecological violence are facing some resistance from some healthcare professionals. Although it seems that midwives have acknowledged the issue for some years now, there is more reticence to frame those acts as 'violence' among other healthcare professionals. However, some initiatives have been taken to improve their understanding of the issues at stake, or to foster positive changes in their work. Those developments

illustrate a greater concern among healthcare professionals to better understand the issue, and to reflect upon the relationship between patients and caregivers.

8.2. Recommendations

Based upon the findings from the research carried out at EU and Member States level and recommendations developed at international and EU level[453], the study developed a set of recommendations targeting different stakeholders, including:

- European Institutions and bodies
- Member States
- Healthcare providers and
- Women's rights groups/associations

The recommendations should aim at responding to the issues and challenges identified above, and therefore, have been divided as follow:

- Recommendations to improve understanding and recognition of obstetric and gynaecological violence;
- Recommendations to improve the legal framework applicable to obstetric and gynaecological violence and access to justice;
- Recommendations to improve prevention, and to provide more respectful care.

Those are described in more detail below. Each proposed recommendation is accompanied by a short rationale and identifies the role of different stakeholders in its implementation.

8.2.1. Recommendations to improve understanding and recognition of obstetric and gynaecological violence

Obstetric and gynaecological violence is a pervasive form of violence against women, perpetrated through normalised healthcare practices. As previously discussed, identifying and naming those practices as manifestations of gender-based violence can be difficult, both for the victims and healthcare professionals (who are placed in a position where they are 'perpetrators'). Raising awareness of this form of violence is therefore instrumental to any policy aiming at tackling and preventing its manifestations. To do so, it is necessary to conceptualise the phenomenon and to agree on a definition. Raising awareness of the phenomenon also implies making it more visible, and therefore, another recommendation focuses on the need to improve data collection on obstetric and gynaecological violence. Importantly, since there is considerably less data and less awareness of gynaecological violence compared to obstetric violence, more efforts should be geared towards collecting data

[453] 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, A/74/137, available at: file: https://documents.un.org/doc/undoc/gen/n19/213/27/pdf/n1921327.pdf?token=HPHOjhSkMZxcanmL2p&fe=true; Parliamentary Assembly of the Council of Europe (PACE), Resolution 2306 (2019) of 3 October 2019, available at: https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28236; European Parliament resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health (2020/2215(INI)), available at: https://www.europarl.europa.eu/doceo/document/TA-9-2021-0314_EN.pdf; European Parliament resolution of 15 February 2023 on the proposal for a Council decision on the conclusion, by the European Union, of the Council of Europe Convention on preventing and combating violence against women and domestic violence (COM(2016)0109 — 2016/0062R(NLE)), available at: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52023IP0047; NGO recommendations, e.g.IPPF European Network (2022). Gynaecological & Obstetric Violence. Available at: https://europe.ippf.org/sites/europe/files/2022-12/Gynaecological.pdf

specifically on gynaecological violence. Finally, efforts should be made to improve women's, healthcare professionals' and society's understanding of this violence.

Table 2: Define obstetric and gynaecological violence

Define obstetric and gynaecological violence	
A lack of a common understanding of what obstetric and gynaecological violence is makes it difficult to recognise its existence and identify its manifestations. The variety of medical practices, including different interpretations or lack of knowledge of evidence-based medicine and implicit biases of healthcare professionals, have normalised practices that can constitute harmful practices. In addition, without a proper definition, it is also difficult for women to self-identify as victims of violence, and to seek redress. Having a clear definition can also help lower resistance from obstetric and gynaecological professionals (who themselves demand for more clarity on the concept and its manifestations).	
Role of different stakeholders	
European Institutions and bodies	Efforts should be made to **promote a reflection at EU level on the definition of obstetric and gynaecological violence**. Relevant EU institutions and agencies (including the European Commission, the European Institute for Gender Equality, and the Fundamental Rights Agency) should use their convening power to set up **working groups** composed of different stakeholders (including obstetric and gynaecologists organisations at EU and international level, midwives organisations, women's rights associations, EU level users/patients' associations). The purpose of these working groups should be to reflect and agree upon minimum components of an operative **definition for obstetric and gynaecological violence as well as on minimum standards** to ensure respect for women's rights and their dignity, to guarantee respect for free and prior informed consent (and in particular on how to ensure that in case of cascading medical acts) and protection from inhumane and degrading treatment, and combat physical and verbal abuse **in antenatal, childbirth and postnatal care**. The European Commission should bring the issue of obstetric and gynaecological violence to the agenda of the newly established **EU network on the prevention of gender-based violence and domestic violence** (2023). The European Commission and the Council should invite Member States and stakeholders to discuss issues in relation to the definition, prevention, as well as exchange knowledge and good practices, and to assess how some specific forms of obstetric and gynaecological violence could be covered by the Istanbul Convention.
Member States	Launch and support a **reflection on the definition of obstetric and gynaecological violence** at country level, involving relevant decision-making institutions (including Health Ministries, Gender equality/women's rights institutional machineries), but also professional healthcare organisations, women's rights organisations and users/patients' associations. This could take the form of a dedicated working group hosted by the gender equality institutional machinery. Fund qualitative research looking at the manifestations of obstetric and gynaecological violence in different settings and identifying groups most at risk. Support initiatives carried out by civil society organisations to collect women's testimonies on the issue in order to gather evidence on the phenomenon.

Healthcare professionals and representative organisations	Promote participation of healthcare professionals to those working groups tasked with defining obstetric and gynaecological violence. Launch an internal reflection on issues related to obstetric and gynaecological violence with women's and patients' organisations.
Women's rights and users/patients' associations	Create a space dedicated to obstetric and gynaecological violence in campaigns and advocacy work.

Table 3: Measure obstetric and gynaecological violence

Measure obstetric and gynaecological violence	
The study shows that until now, it has been difficult to assess the prevalence of this form of violence, which contributes to making invisible its manifestations and limiting the understanding of this violence as a structural phenomenon. Without (comparative) data, identifying the extent of this violence, its manifestations, and who and how some groups of women might be more exposed than others, proves to be arduous. The absence of large scale prevalence studies carried out at Member State level makes it hard to advocate for legislative or policy changes (as seen in Portugal, where the proposed legislative improvements were not pushed forwards due, in part, to the lack of official statistics to support the claims), but also to advocate for better prevention measures (including funding for CSOs or training for healthcare professionals). Surveys should be carried out to understand the scope of the issue, but as often the case with data collection on gender-based violence, those surveys should be carried out in parallel with awareness-raising measures (targeting both society and healthcare professionals). Those initiatives might initially reveal a greater awareness of obstetric and gynaecological violence. As with data on gender-based violence, the more support there is from public authorities, the less under-reporting there will be. Better recognition of these situations is the first step towards their elimination.	
Role of different stakeholders	
European Institutions and bodies	**Harmonise data collection** on issues related to obstetric and gynaecological violence at EU level. Work should be undertaken jointly by **EIGE and Eurostat** to identify existing data collected at Member State level or existing data collection exercises in which issues related to obstetric and gynaecological violence could be integrated (e.g. perinatal surveys carried out in some Member States). Similarly to what has been done to harmonise administrative data on violence against women across the 27 Member States, an assessment of the existing data available from healthcare institutions (e.g. through collaboration with Member States' Health Ministries) could be carried out and followed up by some practical recommendations promoting a harmonised approach on data collection, with minimum standards[454].

[454] Such an assessment could be funded under the Citizens, Equality, Rights and Values programme(CERV) –Daphne strand (fight against violence, including gender-based violence) (https://ec.europa.eu/info/funding-tenders/opportunities/portal/screen/programmes/cerv); alternatively, it could be carried out, for instance, through a pilot project proposed by the European Parliament, (https://www.europarl.europa.eu/thinktank/en/document/EPRS_ATA(2019)640130)

	The **European level survey on violence against women** carried out every four years under the aegis of Eurostat should also contain some **questions related to obstetric and gynaecological care** received by women and girls across Europe (on the basis of the findings from the **EU network on the prevention of gender-based violence and domestic violence** regarding the potential inclusion of some specific forms of obstetric and gynaecological violence under the framework of the Istanbul Convention – see recommendation 1). Alternatively, reflection should be carried out on the opportunity to include relevant **questions in Euro-Peristat**[455], the EU survey (funded under the Health Programme) monitoring and evaluating perinatal health in Europe by producing indicators on health and care of newborn babies and mothers (especially since the study covers the post-partum period).
Member States	**Working groups** (mentioned under Recommendation 1) should be tasked with reflecting **on how this topic can be included in existing data collection exercises** carried out on issues related to women's health (e.g. perinatal surveys) and discuss matters in relation to using proxies/defining them. This has been started in France, with the latest perinatal survey (see section 2 on prevalence) now including questions related to obstetric violence (but without framing it as such and using proxies to assess care received by women during and after birth). **Public health survey on women's health** should include dedicated questions to gynaecological follow-up; consent; etc. For this, Member States could draw inspiration from national surveys carried out in some South/Central American countries (like ENDIREH in Mexico, which addresses the issue of obstetric violence in a nation-wide survey[456]). **Provide funding and training to improve data collection in healthcare facilities** (e.g. 'Birth Debriefing' in Austria). **Encourage healthcare institutions to collaborate with research institutions** to gather data on relevant practices through funding or other types of incentives.
Healthcare professionals and representative organisations	Contribute to the work undertaken to provide a practical definition of the phenomenon and to measure violence by **reflecting upon available proxies at national/practice level.** **Collaborate with researchers, support access and assess existing data.** Encourage **practitioners to participate in European reports on perinatal health**.

[455] https://www.europeristat.com/

[456] Instituto Nacional de Estadística y Geografía, Encuesta Nacional sobre la Dinámica de la Relaciones en los Hogares (ENDIREH), see questions p. 20 and 21 on obstetric violence.

Table 4: Support initiative to raise awareness on obstetric and gynaecological violence

Support initiative to raise awareness on obstetric and gynaecological violence	
As shown through the research, over the past 10 years, CSOs across Europe have initiated many campaigns and activities to raise awareness of these forms of violence and their consequences on women's physical and mental well-being. Going beyond, they have contributed to shedding light on gender inequalities in health in general and revealed how obstetric and gynaecological violence is also a form of gender-based discrimination in healthcare. The consequences of obstetric and gynaecological violence are not to be minimised, and they can have a devastating impact on specific groups of women (as shown in section 2). However, in spite of these initiatives, in the majority of Member States, obstetric and gynaecological violence has not been placed at the forefront of the agenda. Even in countries where available data shows how widespread some forms of this violence can be, women, healthcare professionals and society at large do not recognise those manifestations as such. Raising awareness on this form of violence is therefore instrumental to any policy aiming at tackling and preventing its manifestations and its consequences. In addition, applying an intersectional approach to the understanding of obstetric and gynaecological violence is crucial given that marginalised women and women in situations of vulnerability may be more at risk of experiencing obstetric and gynaecological mistreatments than other women.	
European Institutions and bodies	**Support EU level campaigns** aimed at strengthening the nexus between women's rights and health/sexual and reproductive rights. For instance, the European Parliament could use the European Gender Equality Week to raise awareness of this specific form of violence.
Member States	Take actions to **strengthen women's awareness of their rights** during obstetric and gynaecological care. This could be done by ensuring that women have access to comprehensive information concerning their rights during gynaecological care and during childbirth, and by concretely implementing sexual and reproductive rights education. **Raise awareness among healthcare professionals** by adding mandatory training on gender bias in medicine to healthcare professionals training curricula, or by adding specific courses on obstetric and gynaecological respectful care and violence against women in the training curricula for future obstetricians and gynaecologists (such as it has been done in France (see section 7), although only in a couple of universities). **Ensure that existing guidelines** on evidence-based medicine (such as the WHO) are **accessible/available to healthcare professionals** and that **they have the capacities to implement** those guidelines. In acknowledging the significant work done by CSOs to raise awareness on the issue, Member States should **launch calls for proposals** (similar to the one launched in Belgium – see section 5) to **fund innovative initiatives to raise women's and healthcare professionals' awareness and improve their access to evidence-based obstetric and gynaecological care**. Through funding and incentives, Member States should **foster the intervention of specialised CSOs into healthcare facilities to train personal** (e.g. Poland, see section 7.2.3).

Healthcare professionals and representative organisations	Raise awareness about disrespectful care, reflection on consent, and gender bias in medicine that perpetuate unequal power relations between women patients and carers, among students and professionals. Raise awareness on existing sanctions when care is not provided according to evidence-based medicine standards. Ensure patients' right to information are well understood and respected by students of healthcare professionals, including the obligation to provide information and services to enable women to have options and make their own informed choices about treatment, care and support (e.g. guidelines developed in the Netherlands, see section 7). Collaborate with women's and patients' organisations to provide comprehensive training to students and professionals.

8.2.2. Recommendations to improve the legal framework applicable to obstetric and gynaecological violence and access to justice

The study shows that victims refrain from seeking redress because they lack awareness of their rights; they doubt the effectiveness of the procedures; they fear experiencing revictimization (also because of stereotypes, sexism, condescension and paternalism, still widespread in both healthcare and courts); of the costs and length of judicial proceedings; of the difficulty of finding a lawyer specialised in the issue, etc. The root of the problem lies in the fact that gender-based violence in the medical world, and in particular in gynaecology and obstetrics, remains unacknowledged in society, and therefore, legally.

Table 5: Improve reporting mechanisms

Improve reporting mechanisms	
Research has shown that existing reporting mechanisms are almost never used. To improve access to justice, the applicable legal framework must first be improved.	
European Institutions and bodies	**The EU should make use of its competence** (Articles 82(2), 83(1) TFEU and article 168) **and recognise obstetric and gynaecological violence as a form of gender-based violence**, taking into account the particularity of this violence, setting up minimum standards in maternity, pregnancy and birth-related care, including the principle of free and informed consent for any medical treatment or intervention, providing comprehensive measures for victims' protection, support and access to justice as well as the prevention of such violence (e.g. including this form of violence in the scope of **the Directive to combat violence against women and domestic violence**[457]). The **European Commission should include the most serious forms of obstetric and gynaecological violence in the Recommendations on the**

[457] A political agreement has been reached on the proposal on 6.02.2024 (https://www.europarl.europa.eu/meetdocs/2014_2019/plmrep/COMMITTEES/LIBE/DV/2024/02-15/VAW-provisionalagreement_EN.pdf) and obstetric and gynaecological violence is not mentioned in the instrument. However, by five years after the end of the transposition period for the Directive, the Commission is expected to carry out an evaluation of it impact, to assess in particular whether an extension of the scope of the Directive and the introduction of new offences is necessary. If so, the report will be accompanied by a legislative proposal

	prevention of harmful practices against women and girls that is currently on the agenda of DG Justice.
Member States	**Reinforce the legal framework applicable to obstetric and gynaecological violence**, including, combating any form of gender-based violence in gynaecological, antenatal, childbirth and postnatal care; ensuring respect for human rights and women's dignity, as well as an informed choice in maternity, pregnancy and birth-related care; combating any form of degrading treatment, physical and verbal abuse in healthcare settings, discrimination on the ground of sex as well as on any other grounds (intersectionality); and reinforcing procedures that guarantee respect for free and prior informed consent, taking into account that childbirth often implies a cascade of acts and that a general consent to 'any acts necessary during childbirth' does not respect the principle of free and informed consent. **Ensure independent complaint systems** are in place at the national level to address cases of obstetric and gynaecological violence, and that those systems include categories related to **obstetric and gynaecological care** and are easily accessible to women. **Provide assistance and support to victims to file a complaint** (via judicial or extra-judicial proceedings) by personnel qualified to treat victims of gender-based violence. This could be done by ensuring CSOs working on supporting women's access to justice have sufficient fundings to operate. **Train healthcare professional, legal professionals (lawyers and judges), as well as all people involved in the redress avenues** (this includes members of professional disciplinary chambers, helpline for patients' rights, hospital services or specific state organisations providing information on how to seek redress) **on the applicable legal framework** for cases of obstetric and gynaecological violence (rights of patients, in particular of free and informed consent and informed choice in maternity, pregnancy and birth-related care; women's human rights and non-discrimination principles; physical and psychological violence), as well as on treatment of victims of gender-based violence. **Train law enforcement authorities** on obstetric and gynaecological violence (e.g. as it has been done in Portugal, see section 7), including in particular **how to deal with victims** of such violence. **Provide a specific procedure so that victims do not need to confront the perpetrator** (i.e. exclude any forms of conciliation/mediation measures in case of VAW, as per the Istanbul Convention). Systematise a process whereby complaints that relate to acts that could already constitute **VAW crimes** (e.g. rapes) can be transmitted **to criminal judicial authorities**.
Healthcare facilities	Have a **gender-based violence referee within the institution**.
Healthcare professionals and	Raise awareness on what behaviours/attitudes/acts are inappropriate in the healthcare system and **denounce and prohibit** those acts (including gender bias) **in the code of medical ethics**/code of conduct.

representative organisations	Communicate on disciplinary procedures for healthcare professionals found guilty of those acts.

8.2.3. Recommendations to improve prevention and obstetric and gynaecological care

Current conventional medical training focuses on pathology. This training, combined with a healthcare system crisis in many Member States, means that medical procedures are carried out habitually with little time to take into account patients' individual characteristics and needs, which becomes a breeding ground for obstetric and gynaecological violence. To combat obstetric and gynaecological violence, it is important to enable carers to change the way they 'care', and to fundamentally transform the relationship between patients and healthcare professionals. But in order to do so, resources are needed.

Table 6: Reducing over-medicalisation to rehumanise obstetric and gynaecological care

Reducing over-medicalisation to rehumanise obstetric and gynaecological care	
Women with a low obstetrical risk are subjected to unnecessary medical interventions when they give birth in facilities with a high level of medicalisation. This has an iatrogenic effect on their mental and physical health, and often does not meet their wishes. Nevertheless, there are models of obstetric and gynaecological care that can meet the needs of both women and carers, and whose effectiveness has been scientifically evaluated. For instance, research has shown that continuous support during labour may improve outcomes for women and infants, including increased spontaneous vaginal birth, shorter duration of labour, and decreased caesarean birth, instrumental vaginal birth, use of any analgesia, use of regional analgesia, low five-minute Apgar score and negative feelings about childbirth experiences[458]. Midwives and women have been campaigning for several years to be able to provide one-to-one care, which is a model of care that protects women and restores meaning to the profession of many midwives, who can then practice their art in satisfactory conditions. Women with a low obstetrical risk who wish to do so should be allowed to give birth safely in places that are not over-medicalised. Therefore, there is a need to diversify birthing facilities and encourage the opening and operation of midwifery-led birthing centers, which have already demonstrated in many European countries that the physical and emotional safety of women and their families is respected, with a very low intervention rate.	
European Institutions and bodies	Salutogenesis, which focuses on the factors that promote health and well-being rather than studying diseases, is at the heart of this need for a paradigm shift. **DG Sante, in collaboration with EIGE**, should be active in promoting this paradigm shift. The **European Commission should develop recommendations on common European standards and good practices on gynaecological, antenatal, childbirth and postnatal care**, in particular concerning the first consultation, which integrates the specificities encountered by minorities like

[458] Bohren et al, 2017

	women with disabilities, lesbian and migrant women; and the process of asking consent.
Member States	**Disseminate and enforce the recommendations for good practice from the World Health Organization**, including recent recommendations that encourage less medicalisation of gynaecological follow-up and childbirth[459]. Positive examples have been identified in Luxembourg, where the Health Scientific Council has developed some clear guidelines for healthcare professionals on how to implement those recommendations (albeit only focusing on obstetric violence)[460]. **Strengthen initial and continuous training for medical and paramedical professionals in terms of good treatment, respect for consent and evidence-based medicine** (e.g. similarly to what is being done in Ireland[461]). **Introduce or strengthen the presence of patient'' associations and social science research in medical training courses** in order to enhance the listening and empathy skills of carers. Take steps to **diversify care structures** to better respond to the principle of women's autonomy, offer them a real choice and reduce medicalisation and automated actions and care, which dehumanise and expose them to an increased risk of violence (e.g. launching initiatives to assess impact of birthing houses in LU, BE, NL for low risk/normal patients; promoting one-to-one care with midwives; offering women the possibility to be accompanied by the person of her choice during examinations and interventions). **Support, via funding, the creation of midwifery-led birthing centers annexed to hospitals**, to provide support in cases of medical emergencies (see recommendation of Belgian Senate Committee). **Encourage comprehensive care for women and families**. Midwives, whose expertise is based on physiological support, are at the forefront of this holistic approach. There is a need to support midwifery research, which is currently working to keep women physiologically healthy by developing research into salutogenesis and care structures based on respect for physiology.
Healthcare professionals and representative organisations	**Promote knowledge and dissemination of evidence-based medicine guidelines** among students and professionals.

[459] Organisation Mondiale de la Santé, Recommandation sur les soins intrapartum pour une expérience positive de l'accouchement - Transformer le soin des femmes et des nourrissons pour améliorer leur santé et leur bien-être, février 2018.

[460] violences-gynecologiques-et-obstetricales.pdf (cesas.lu)

[461] Introduce gender-sensitivity and unconscious bias training, beginning in undergraduate curriculums and continuing across professional development. This should be co-designed with a diverse cohort of women, including those who are experts by experience on different health conditions. Ensure that training emphasises that clinical best-practice and shared decision-making go hand-in-hand and equips professionals with the skills and knowledge necessary to support meaningful service-user input

Table 7: Allocate appropriate human and financial resources to obstetric and gynaecological care

Allocate appropriate human and financial resources to obstetric and gynaecological care	
Some of the good practices and recommendations identified above are not new, and their lack of implementation is not only linked to a lack of knowledge or goodwill among healthcare professionals, but also to a **lack of appropriate human and financial resources** allocated to healthcare systems, that hinders the provision of good care and good relationships between patients and carers. In many Member States, poor working conditions of healthcare staff, insufficient number of caregivers and excessive workloads, large size of maternity wards, shortened stays of parturients, etc., do not allow healthcare providers to provide good care. Enabling the concrete implementation of the good practices and recommendations mentioned above can only be done by strengthening human and financial resources, including by financing initiatives that better respond to women's needs in terms of obstetric and gynaecological care.	
European Institutions and bodies	**Provide recommendation to Member States** on how to improve the infrastructure, training and working conditions of health professionals so that they can offer humane and personalised care. This could be done through the work of the European Commission's Expert group on Health Systems Performance Assessment[462]. Obstetric and gynaecological care could be put on the agenda of the annual 'Priority areas' this group focuses on. Through its work around tools and methodologies, the expert group could support the development of strong evidence-based approaches in relation to obstetric and gynaecological care.
Member States	Allocate **more resources** to obstetrics and gynaecology departments (and more generally, all public institutions offering obstetric and gynaecological care) both in terms of organisation, infrastructure and the number of carers (the documents and interviews carried out in the framework of the study demonstrate overworked professionals, understaffed maternity wards, and a limited number of healthcare professionals). In relation to gynaecological care, **diversify the places follow-ups** can be performed (and avoid 'medical deserts'), potentially by extending the skills of healthcare professionals to carry out these follow-ups (as was done in France for contraception, abortions etc.). **Finance pilot initiatives that better respond to women's needs in terms of obstetric and gynaecological care** (e.g. birthing houses).
Healthcare professionals and representative organisations	Improve workplace culture by increasing support and acknowledgement, offering time and space for debriefing and implementing regular rotation of staff.

[462] https://health.ec.europa.eu/health-systems-performance-assessment_en

Annex 1. Overview of data and information collected in the 27 EU Member States

A1.1 Initiatives to raise awareness on the issue in the EU 27 MS

Country	Title of the activity Organiser	Short summary	Target audience	Date
BE	Awareness raising on the report from Senate Centre for Research on Deviance and Penalty (CRID&P), UCLouvain	Webinar to promote dialogue between stakeholders in health, the associative sector and the political scene on obstetric and gynaecological violence.	Medical staff, stakeholders	10/23
	Nos corps, nos soins, nos choix", 3 jours pour sensibiliser aux violences gynécologiques et obstétricales **(Our bodies, our care, our choices", 3 days to raise awareness of gynecological and obstetric violence)** Fédération des Centres Pluralistes de Planning Familial (FCPPF)	Three days of activities, workshops, screenings, theatrical performances or even webinars to raise awareness on gynaecological and obstetric violence.		06/23
	Article 'Een bevalling maakt je niet ontoerekeningsvatbaar' Heleen Debruyne in the Belgian quality newspaper De Standaard	Criticism to a well-known Belgian gynaecologist who stated that doctors should be able to make decisions, even if the mother does not approve. Debruyne posits that consent should be obtained for every medical intervention.		04/21
BG	Да превърнем раждането в позитивно преживяване	Promotion of the current recommendations	Pregnant women	01-03/19

Country	Title of the activity Organiser	Short summary	Target audience	Date
	(To make childbirth a positive experience) Network for modern maternity care	of the WHO for the management of uncomplicated childbirth.		
CZ	**"Let's tackle obstetric violence"** Liga lidských práv (The Human Rights League)	The campaign established centres for victims of obstetric violence and involuntary sterilisation, trained 250 health care professionals in communication, evidence-based care, and law, and created free educational videos.	Pregnant women, parents, victims of involuntary sterilisation; health care providers	2021-23
	"It´s enough!" (Už dost!) Group of NGO'S + foundations (Unipa, HAM, Liga lidských práv, Nadační fond Propolis, Amma Dula Academia)	The website informs about obstetric violence, victims' experiences, and publishes valuable information for both caregivers and women.	General public, pregnant women, health care providers	Not specified
	A festival about pregnancy, childbirth and parenthood HAM	It promotes values such as the need for free choice of birth care and the perception of childbirth as a natural physiological process that should not leave women traumatised.		Held annually
	Růže obětem porodnického násilí / Roses Revolution ČŽL	A number of governmental and non-governmental institutions and organisations		11/23

Country	Title of the activity Organiser	Short summary	Target audience	Date
		involved in the prevention of obstetric violence during the 16 Days of Activism against Gender-Based Violence campaign.		
DE	**Roses Revolution** CSO (2013-2018 private team of moderators, since 2018 NGO Traum(a)Geburt e.V.)	The RosRev is "the mother of all campaigns" against OV in Germany and was the starting point of all public awareness. All organisations work to support the RosRev. Women who experienced violence during childbirth place a pink rose at the door where the violence took place, take pictures and post them on social media.	Women and people who experience violence in the birth room	Held annually (25/11)
EE	**#mina ka sünnitajana/ Me too movement focused on obstetric violence** MTÜ Emale/non-profit organisation To Mother	The campaign uses stories and surveys to shed light on the violation of women's rights during pregnancy, childbirth and postpartum.	Women General public Healthcare professionals	2021 ongoing
EL	**What is gynaecological and obstetric violence? #ShowRespectNoToViolence** OVO Hellas	On the occasion of the 16 days of activism against GBV, OVO Hellas launched an online campaign in order to ask women to report	Women victims of gynaecological and/or obstetric violence	11/20

Country	Title of the activity Organiser	Short summary	Target audience	Date
		incidents of obstetric violence to their website.		
ES	**Haloperidol en el parto nunca más** El Parto es Nuestro	Campaign launched on 8 March 2021 aimed at eradicating the dangerous and unscientific practice of administrating haloperidol to women in labour.	Society at large, women and all stakeholders	03/21–-ongoing
	Stop Kristeller: Cuestión de gravedad El Parto es Nuestro	Campaign aimed at raising awareness about the alarming practice of the Kristeller manoeuvre.		06/14–-ongoing
	No entres sola El Parto es Nuestro	Campaign to denounce how, to this day, pregnant women are not allowed to go to health appointments accompanied by their partners or people of their choice.		07/21–-ongoing
	La voz es nuestra El Parto es Nuestro	Campaign to support women in asserting their wishes, desires, and opinions about what happens during and after childbirth.		
	Congreso Internacional sobre Violencia Obstétrica (The International Congress on Obstetric Violence) GIENF-Nursing Research Group	The International Congress was born out of the need to train future health professionals with a clear vision of	Society, women and healthcare professionals	Held annually in May

Country	Title of the activity Organiser	Short summary	Target audience	Date
		gender, competence and a critical view of male violence in general and obstetric violence in particular.		
FR	**Awareness raising activities of small scale** IRASF	Over the past years, IRASF has organised several small awareness raising activities.	Women, healthcare professionals	One-off
	Cine debat on obstetric and gynaecological violence Planning familial 13 and IRASF		Women	One-off
IE	**16 Days of Activism Against Gender-Based Violence** Women's Aid and Abortion Rights Campaign	The campaign looked at the issues of obstetric and reproductive violence, and how they apply to people's lives in Ireland and across the globe.	General public	2020, for 16 days
	#BetterMaternityCare Campaign Women Ascend	The campaign aims at ending the restrictions on birth partners' access in maternity hospitals.	HSE	2021, over a year
	#AbortionAccess National Women's Council	The campaign stresses the ongoing difficulties of accessing abortion in Ireland despite the 2018 revocation of the 8th amendment.	Government	05-06/23
	@maternityire Jane Travers	A twitter account that encourages women to be open about their experiences in Ireland's	General public	2013

Country	Title of the activity Organiser	Short summary	Target audience	Date
		maternity hospitals.		
	Campaign on the Issue of Informed Consent and National Guidelines for Clinical Practice in Maternity Care AIMS Ireland	AIMS Ireland has been lobbying the Minister for Health and the Health Services Executive (HSE) to review service user consent policy in Irish maternity services and for the creation and implementation of National Guidelines for Clinical Practice in Maternity Care.	Government	2008
HR	**Prekinimo šutnju** Roda – Parents in Action	Campaign aimed to raise awareness on obstetric and gynaecological violence. The 2018 campaign began after Ivana Ninčević Lesandrić, then a member of parliament, told her story of surgical miscarriage without anaesthetic in parliament.	General public, policymakers	2014, 2018
	Sloboda rađanju Roda – Parents in Action	Regional campaign organised by NGOs from Croatia, Slovenia, Bosnia Herzegovina, Serbia and Macedonia.		2015
HU	**'NŐ a hangunk' (WOMAN is our voice)**	The aim of the national movement is to	National	2021

Country	Title of the activity Organiser	Short summary	Target audience	Date
	Másállapot	draw attention to the fact that the quality of labour and birth of the Hungarian maternity care system in its current form is only good for a few.		
IT	**Fiocchi in ospedale (Flakes in the hospital)** Save The Children	Although not directly aimed at addressing ob-gyn violence, the project strengthens future and new parents' awareness about their rights and the services offered in the hospital for a more humanised and less medicalised birth.	Future and new parents	Ongoing throughout the year
	#ANCHEAME (#METOO) #ANCHEAME group	Online awareness raising campaign launched by a group of 14 activists to educate about the phenomenon of ob-gyn violence and collect testimonies from other women. The group is currently working on a legislative proposal to be submitted to the Italian parliament to address cases of ob-gyn violence.	General public, women victims of ob-gyn violence	Ongoing
	#Bastatacere OVOItalia	Online awareness raising campaign		2016

Country	Title of the activity Organiser	Short summary	Target audience	Date
		on facebook giving mothers room to share their experiences of obstetric violence.		
LT	**Open lecture "Obstetric and gynaecological violence: from Camille Laurens to social media."** French Institute in Lithuania and Vilnius University	The experience of France dealing with obstetric and gynaecological violence (project MotherNet funded by horizon 2020).	General public	06/23
	Human rights violations and violence in midwifery NGO Vilniaus moterų namai/Vilnius Women House	Online freely accessible literature review.	General public	
	Rožių revoliucija (Rose revolution) Private initiative	International awareness campaign against obstetric violence.	Women	25-Nov-15
	Akušerinis smurtas (Obstetric violence) Lithuanian Medical Student Association	Open lecture on how to recognize and prevent obstetric violence.	General public	14-Nov-23
	Obstetric violence: mothers open their wounds NGO initiative	Awareness raising investigative journal article about obstetric violence (project Media4Change – Future Story Lab financed by DG CONNECT)	General public	Online since 04/22
LU	**Rencontre ouvert e : La violence obstétricale et gynécologique, parlons-e n !** Platform JIF	The event discussed the different forms of obstetric and gynaecological violence and the opinions of healthcare professionals.	Women/JIF members	11/21

Country	Title of the activity Organiser	Short summary	Target audience	Date
	Feminist march of 8th March 2023 Platform JIF	IWD 2023 march addressed the issue of obstetric and gynaecological violence, with specific demands including criminal prosecution, data collection and home births facilitation.	Women/JIF members	03/23
LV	The experience of violence during childbirth is still relevant in Latvia Latvian National Radio "Family studio"	Discussion on childbirth violence and prevention. The introduction of the program voiced a collection of women's experiences of violence.	General public	07/22
	Exhibition 'Being a parent. First year in portraits' with a public debate on obstetric violence NGO "My first year too"	Public debate during which women's stories of violence were read.	General public	2022
	Systemic violence in childbirth: A conversation following research Publicist Agra Lieģi-Doležko and doctor of communication sciences Olga Procevska	Discussion of research results and a podcast on systemic violence in childbirth.	General public	03/23
MT	#Road2EndFGM	Annual Campaign of the Network "A roadmap to end FGM".	General public	01/23
NL	Action #genoeggezwegen (#breakthesilence) Birth Movement	Yearly action wherein people share their experiences with obstetric violence via the social	General public	Annual lasting 3 weeks since 2016

Country	Title of the activity Organiser	Short summary	Target audience	Date
		media of the Birth Movement.		
PL	**Walczymy o normalność (We are fighting for normality)** The Childbirth with Dignity Foundation	The campaign aimed to draw public attention to the problem of failure to respect the rights of female patients in maternity wards.	Women, medical staff, stakeholders	2004
	Nie daj się naciąć (Don't Get Cut Action) The Childbirth with Dignity Foundation	Campaign against routine episiotomy cutting during childbirth.		2008
	Pozwólcie nam się przywitać (Let us say hello) The Childbirth with Dignity Foundation	Campaign for first skin-to-skin contact after childbirth.		2011
	Te słowa zostają w nich na zawsze (These words stay with them forever) The Childbirth with Dignity Foundation	The campaign aimed to draw public attention to the problem of failure to respect the rights of women patients in maternity wards.		2014
	Rodzę – mam prawn (I am giving birth - I have rights) The Childbirth with Dignity Foundation	A campaign to make women aware of their rights during childbirth. Project "Guarding Standards of Perinatal Care"		2015
	The Childbirth with Dignity Foundation	Survey for women on the quality of maternity care, ranking of maternity hospitals based on women's experiences.		2018-22

Country	Title of the activity Organiser	Short summary	Target audience	Date
	Przemoc położnicza STOP 2022 (STOP Obstetric violence) The Childbirth with Dignity Foundation	Awareness raising campaign on obstetric violence		2022-24
	Obywatelki na straży godnego porodu (Women on guard of dignified childbirth) The Childbirth with Dignity Foundation	The project aims to activate women in local activities to improve perinatal care.		2023-24
	You have the right to complain The Childbirth with Dignity Foundation	Information campaign aimed at increasing awareness of women's rights during childbirth and engaging postpartum women whose rights were violated during childbirth.	Women	2023
	16 dni przeciwko przemocy (16 days against violence) The Childbirth with Dignity Foundation	Awareness raising campaign on obstetric violence	Women, medical staff, stakeholders	2023-24
PT	National campaign on communication of reproductive rights *Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto*	Campaign to inform professionals and the community about rights during pregnancy, childbirth and the postpartum period.	General public, professionals	n/a
RO	ACCESS-- Advocacy, Empowerment, Consolidation for Equality in Health and Safety FILIA	Multiple-event campaign focused on violence against women, maternal and reproductive health, tools and	Women	03/21 lasting over two years

Country	Title of the activity Organiser	Short summary	Target audience	Date
		tactics to exercise one's rights.		
	Pregnancy and childbirth Mothers to Mothers	Requested the Romanian Government to introduce and implement legal, policy, and support measures to tackle obstetric violence.	Romanian Government	2023
SE	Racism and behaviour in healthcare The National Board of Health and Welfare	A web-based educational program for racism awareness in general healthcare.	Healthcare professionals and managers	Launched December 2023
SI	#breakthesilence campaign Institut Umbilica	Collected cca 150 stories which were denied by doctors in media.	General public/government	2018
	Story of my birth project Institut Umbilica	Questionnaire aimed at discovering problems in maternity care with a focus on patients' rights.	Public stakeholders	2023/2024
	The rights of the birthing woman project – Natural beginners	A webpage with women's rights in maternity care and collection of traumatising stories to make an analysis of factors for trauma.	Public stakeholders	2021 -
SK	Podcast Ženských kruhov (Women´s Circles Podcasts)– - NGO Ženské kruhy	Podcast series on pregnancy, obstetric care, reproductive health and various forms of obstetric-gynaecological violence.	General public, (pregnant) women	n/a
	Barriers in access to health care: Results of a survey of	Survey on the availability and	General public	n/a

Country	Title of the activity Organiser	Short summary	Target audience	Date
	the experiences of women, girls and parents from Ukraine with temporary refuge with health care in Slovakia NGO Ženské kruhy	quality of health care for women from Ukraine.		
	Svedectvá, Príbehy (Testimonies, Stories) NGO Ženské kruhy	Women's stories and experiences of childbirth and other related care	General public	n/a
FI	**Kamppailu synnytyksestä – Suomalaisen synnytyskulttuurin murros (Battles over birth – Transition in the Finnish birth culture)**	Five researchers have studied birth activism, including Me too in childbirth campaign, and are now writing a book about it. They have also trained many staff at birth hospitals around the country.	General public	2020-26

A1.2 Initiatives to collect women's voices

Country	Initiative
AT	Roses Revolution Österreich–- On November 25th, on the International Day against Violence against Women, those affected will place a letter and a rose at the places where they experienced violence during birth, pregnancy or the postpartum period to set an example for dignified birth support. The Austrian version of this initiative was founded by midwifes with communication happening via Facebook and Instagram.
BE	- The Citizen Platform for a respected birth led a research (questionnaire) in 2021 in the Federation of Wallonia and Brussels region, surveying 4,226 women. Data collected also by Centre d'épidémiologie périnatale (CEPIP) and du Centre fédéral d'expertise des soins de santé (KCE). - To better understand and eradicate Gynaecological and obstetric violence a study and an awareness and prevention campaign is underway, led by the Council of Francophone Women of Belgium (CFFB). - The non-profit association Synergie Wallonie for equality between women and men is launching a survey for women and girls: "Your Pain, Your Words on the subject of gynecological and/or obstetric violence". - The collaborative site "Go to Gyneco" is the first in Belgium to offer a space for discussion for the lesbian community and to recommend lesbian friendly professionals.

Country	Initiative
BG	There have been two initiatives to collect stories of women of how they have been treated during childbirth: - The women giving birth are telling their stories (Родилките разказват) organized by Mama Ninja (CSO). - Childbirth in stories (Раждането в истории), organised by an individual.
CY	In the context of the European funded (CERV) project RESPECT "Toward a culture of Respectful Maternity Care: Enhancing Provider-Client Shared Decision Making and Informed Choice"(2023-2025) led by the Cyprus University of Technology (CUT, 2023a)*, in October 2023, an online survey on Respectful Maternity Care was launched where women who gave birth in Cyprus in the last 5 years are asked to complete an anonymous online survey in English or in Greek. Instead of using the terms of obstetric or gynaecological violence, the project chooses to use the term Respectful Maternity Care in order to focus on the fundamental right of women to information and informational support as a form of primary prevention of disrespect and abuse.
EE	- The website minakasynnitajana created by volunteers (2021) shares a brief overview of obstetric violence in Estonian language and gives women the opportunity to share their unpleasant childbirth experience by filling out a questionnaire, the first one on obstetric violence in Estonia. The page does not reflect the ethical approval and methodology of the study, it is a google docs questionnaire created as a public initiative. However, while no evidence-based conclusions can be made, the initiative deserves attention to encourage reporting the issue. - One Master`s thesis ("Estonian women's experiences with disrespectful maternity care: an open interview study") is in progress and expected to be completed by Dec 2024. Hopefully, this will provide an output to create a formal definition and to make proposals to change the legislation.
EL	On the occasion of the 16 days of activism against GBV- OVO Hellas (2020) launched an online campaign encouraging women to report incidents of obstetric violence to their website. No data has been published regarding the number of women that responded to this call, the forms of obstetric violence mentioned or their prevalence.
ES	El Parto es Nuestro and Dona Llum collect testimonies in their blogs, social networks and via email. In addition, there have been initiatives, mainly from the private sector, aimed at making obstetric violence visible, such as theatre plays (El útero nimio, Anatomía de una sirena, La Confiança), podcasts (Parir en el Siglo XXI, Radiojaputa, Silenciadas: voces contra la violencia obstétrica), documentaries (VOCES, Parir en el Siglo XXI) and photography (Vulnerables).
FR	- For several years, testimonies from women have been increasing denouncing sexist injunctions, unnecessary medical procedures during childbirth and even sexual violence in the context of gynaecological and obstetrical follow-up. In recent years, there has been a greater willingness to talk about this subject via Twitter and other social media. The concept of obstetric and gynaecological violence emerged on the public discourse thanks to bloggers, social campaigns, reports ("Marie accouche la", "Point du Marie", #PayeTonUtérus #balancetongyneco, "L'histoire de ma copine Cécile", "Livre noir de la gynécologie", "Accouchement: les femmes méritent mieux") and revelations about the practices of certain hospitals, which eventually led to Ministry of Health initiating discussion on consent regarding gynaecological examinations. There were numerous testimonies and complaints of gynaecological violence, some giving rise to legal investigations, in the media over the past years (including a couple involving a Secretary of State).

Country	Initiative
	- Stop VOG (on social media) lists testimonies linked to this violence and publishes them on its social networks. - The institute of research and action for women's health (Institut de Recherche et d'Action pour la Sante des Femmes) collects women's complaints on obstetric and gynaecological violence to gather some 'unofficial' statistics. When victims denounce the same perpetrators/healthcare facilities, they have the possibility to be put in touch to facilitate any legal action. - 'Projet TVO: témoignages de violences obstétricales'(Testimonies of obstetric violence Project) collects women's testimonies of obstetric violence, to draw a map intending to show the plurality of obstetric violence inflicted on women and people when they give birth. The map also aims at helping research carried out on obstetric violence. - A project has also been set up to develop a list of caregivers practicing gynaecological procedures with a feminist approach - The INSERM (governmental research body)'s national survey carried out in 2021 addressed the issue of obstetric violence.
IE	- AIMS Ireland Submission to the Joint Oireachtas Committee on Gender Equality on 4th March 2022. AIMS Ireland campaign for recognition of maternal autonomy and issues surrounding informed choice and informed refusal for women in all aspects of the maternity services. Their day-to-day contact with service users, consumer interest groups and healthcare practitioners help them stay informed of key issues in maternity care and services which then feedback directly to service providers, media, HSE and Government in an effort to improve maternity services on a local and national level. They advocate for obstetric violence to be added to the other forms of gender-based violence. - Survivors of Symphysiotomy—an unfunded volunteer campaign that is the national membership organisation for survivors of symphysiotomy. They are among the 1,500 women who had their pelvises severed in symphysiotomy in Ireland, without their free and informed consent, from 1944 to 1987. In 2019, they submitted to the UN Special Rapporteur on Violence Against Women on the mistreatment and violence against women in reproductive healthcare during childbirth to outline the past and continuing violence and mistreatment routinely perpetrated against women and girls in maternity care that is exemplified by Ireland's practice of forced symphysiotomy.
HR	Hundreds of women testimonies were collected under the #PrekinimoŠutnju (BreakTheSilence) campaign.
HU	- The Másállapotot Facebook page, collects birth stories describing the experiences of mothers giving a picture of obstetric violence and traumatic births across the country. - The igyszultem.hu website collects the experiences of women who have given birth and shares information around hospital practices including inductions, episiotomy, choosing a companion for the birth, allowing to choose birthing position, practices around separating mother and children after birth, practices around paying under the table for doctors.
LT	- Since 2019, the annual study "Mano gimdymas"/"My childbirth" carried out by NGO "Union of Maternity Care Initiatives" is aimed at collecting women's experiences during the childbirth (https://mgis.lt/mano-gimdymas/). This NGO also has a YouTube channel to broadcast conferences, lectures, etc.

Country	Initiative
	- A personal study by Aušra Karnauskienė (2021) aimed at collecting data on obstetric violence experienced during childbirth. She also has a blog on Facebook called "The diary of an obstetrician".
LU	In 2015, a doula, Sandy Girotto-Weinzier, with her experience and awareness of the obstetric violence that currently exists in Luxembourg, launched a first event called The Roses Revolution, intended to denounce and raise awareness among health professionals and the general public about this cause. The event is inspired by a movement that started in Spain. On November 25, the international day against violence against women, all victims of gynaecological violence are invited to leave a rose in front of the room of the maternity ward in which they gave birth. Last year, around fifteen people responded to the call.
LV	PREM – Patient reported experience measure questionnaire. Pilot survey on birth experience conducted in 2023. The survey is modelled upon WHO recommendations (IMAgiNE EURO project) and specifically addresses women's experience at birth. It is organised by the Ministry of Health, Centre for Disease Prevention and Control and the Latvian Association of Gynaecologists and Obstetricians.
MT	In 2017, the Department of Gender Studies of the University of Malta carried out research to identify and explore the barriers faced by women victims of violence when seeking help from state and non-state services as well as those faced by professionals when delivering services to the victims. The research identified a predominantly patriarchal Maltese society as a big barrier which still manifests itself in social attitudes, gender roles and dominant discourses. As a key finding, the research indicates that victims felt they were not sufficiently informed about available services and their rights, poor interagency collaboration, and victims' re-victimisation through the justice system. The University compiled a list of 32 recommendations following this study, including but not exclusively, awareness campaigns, specialist training, promotion of gender sensitive in the justice system, and the provision of handbooks and training to first-response officers and investigators.
NL	The Birth Movement collects women's voices each year in their action #Breakthesilence. In 2016, the movement collated the testimonies into a Black Book, which was handed in at the government.
PL	- Childbirth with Dignity Foundation has been collecting women's voices regarding their perinatal experiences since 1996. Others include collecting experiences regarding reproductive losses (Matecznik Foundation), and disabled women's experiences during gynaecological services "Kulawa Warszaw" Foundation). - Since 2019, Childbirth with Dignity Foundation has been developing a network of local activists–- Guardians of giving birth with dignity. Thirty-five activists from all over Poland were trained. The Guardians increase women's social participation by encouraging them to complete the "Voice of Mother" survey after giving birth, educate women and local communities on their rights in perinatal care, and are also invited to hospitals and offices where they present perinatal care in facilities from the women's perspective. Medical staff cannot participate in the guardian project due to the possible negative consequences of undertaking interventions–- dismissal from work.
PT	The Portuguese Association for Women' Rights in Pregnancy and Childbirth has conducted a survey on the experiences of women in 2012-2015and in 2015-2019.
RO	FILIA Centre, a non-governmental organisation for women's rights, has been monitoring and publishing on situations of discrimination and violence against women when

Country	Initiative
	accessing reproductive and sexual health services. The following forms of obstetric and gynaecological violence were mostly encountered, and documented: - forced gynaecological checking for 'virginity' of girls and young women (fathers or family members forcing girls to go through a gynaecological checking to 'prove' her virginity; the doctor is asked to 'issue' a certificate); - refusal to insert/fix IUDs to young women, or abusive behaviour and mistreatment when they ask to have it fixed. - refusal to perform abortion under 'conscious or religious believes', despite it being legal until the end of the first trimester.
SE	- There is a page on Instagram called @tyst_jag_foder (be quiet, I'm giving birth) where women can share their stories about obstetric violence. There is also another account called @alltserfintut (everything is looking good) where women with vaginal raptures share their stories of mistreatment (and sometimes mention obstetrical and gynaecological violence). There are a few 'birth influencers', typically midwives, with large followings sporadically writing about the issue i.e. @fodamedstod, @instamorskan, @asabea and home birth midwives @barnmorsketeamet. - Birth rights Sweden launched a report in 2022 called Beyond the statistics and collected 400 women's testimonies about maternal health, childbirth, aftercare, and mistreatment in Swedish labour and birth care.
SI	- #breakthesilence campaign 2018–- collection of stories. - Zero tolerance towards violence during childbirth–- collection of stories and preliminary study by NGO Pravice Porodnice Za sočutno ter ženski in otroku naklonjeno strokovno utemeljeno obporodno skrb.
SK	- Vakeras Zorales – Speaking Out: Roma Women's Experiences in Reproductive Health Care in Slovakia (2017) a report by Center for Reproductive Rights and Poradňa that explored the experiences of human right violations and discrimination of 38Roma women in reproductive and maternal health care settings in Slovakia based on in-depth interviews with 38 women living in the eastern part of the country. - Zuzana Límová, Mezi nami (Between Us) (2016), a documentary film on obstetric violence in Slovak maternal hospitals - Online survey on the Violation of Women's Human Rights When Providing a Health Care During Childbirth at Slovakia conducted by Public Defender of Rights of the Slovak Republic. - The book Nahlas (Loud), published by NGO Ženské Kruhy in 2020 brings together 20 stories in which women point out the shortcomings and failures of the healthcare system based on their lived experiences.
FI	The campaign #MetooinChildbirth was initiated by birth activists in spring 2019 with the launch of a website and a Facebook page that invited people to share their experiences of being belittled, insulted, or abused and to be 'part of the change' by speaking out if they had experienced something similar. The mission served as a call to end violations of the right to self-determination and to end violence against women giving birth. This campaign was the first to present the term obstetric violence in Finnish in larger scale and above all in public discussion. However, governmental institutions have not addressed the issue explicitly.

A1.3 Existing organisations providing support to women

Country	Organisation	Activity
AT	Frauengesundheitszentrum	- support to women. - training and awareness raising to healthcare providers. - monitors and further develops existing initiatives to anchor the topic of dealing with violence in the training of health professionals. - networks between experts and actors in the healthcare system and in the area of protection against violence.
BE	Platform for a Respected Birth	A collective bringing together users, health professionals, associations and feminists and advocating for: - the right of women to choose the circumstances of their childbirth in the interest of newborns, mothers and their partners. - obstetric violences to be recognised
	Women and Health	In consultation with partner associations 'Areas to defend' developed a feminist self-defence manual that: - covers the violence and abuse that women can experience throughout life in the context of sexual and reproductive health consultations. - offers ways for women to defend themselves and assert their rights.
	L'ASBL Prémisse	Developed "Don't touch my body without my consent", a prevention guide against gynaecological and obstetric violence.
	Groupe pour l'abolition des mutilations sexuelles (GAMSBelgiquee)	- advocacy. - training on FGM for health professionals.
BG	Bulgarian Helsinki Committee, Maiko mila, Association Estestveno, Network for modern maternity care, Foundation Gender Alternatives.	- awareness raising and lobbying activities. These organisations are advocating for a number of changes to the obstetric care in Bulgaria including: - the provision of publicly available information on consent to birth rights and provision of birth conditions that do not violate these rights. - eradicating physical and/or mental violence on the woman giving birth and the newborn. - adopting professional standards for professionals in the midwifery practice.
	1 naum, Parents academy	educational platforms and hospitals that organise various free activities to educate women about childbirth, procedures during childbirth and when they are needed.
	The Alliance of Bulgarian midwives	- activities to educate midwives, but there is no detailed information on the content of these educational activities.

Country	Organisation	Activity
CZ	**APERIO**	- provides a guide to maternity hospitals. - collects information about individual maternity hospitals in Czechia and the experiences of women who have given birth in these hospitals.
	Liga lidských práv	- provides legal advice; the Legal Handbook for Midwives and Obstetricians is published on the website.
	UNIPA (Unie porodních asistentek; The Union of Midwives)	- fights for the right of midwives right to provide autonomous care for women during childbirth. - the website allows to find and contact a midwife nearby. - provides information for parents and midwives regarding their rights.
	The Movement for Active Motherhood (HAM)	- promotes normal childbirth and friendly prenatal, birth and postpartum care for mother and child in accordance with the latest scientific findings. - publishes informative texts. - organises annual events as part of the World Respect for Childbirth Week. - provides health and legal advice. - organises a cycle of interactive lectures on Healthy Adolescence for primary and secondary schools.
	The Czech Women´s Lobby	- has a working group for obstetrics consisting of professional organisations of midwives, doulas, parents and other non-profit organisations. - promotes informed and free choice of obstetric care. - raises public awareness of "evidence-based-practice". - publishes standard care procedures and data on the quality of care provided in obstetrics.
CY	**Birth Forward**	Respect WATCH project to: - establish a national advocacy and a watchdog mechanism to monitor if perinatal care is delivered with respect. - establish "tools, systems and procedures to systematically record, code, analyse in order to identify patterns and gaps, advocate for redressing those gaps through reporting and recommendations to stakeholders"
DE	**Mother Hood e.V.**	- informs women on their rights. - advocacy work with health stakeholders and politicians. - facilitates a helpline after difficult births.
	Traum(a)Geburt e.V.	- offers support around birth trauma. - has legal info on their website. - organizes the annual Roses Revolution Day of Action against OV. - counsels pregnant women.

Country	Organisation	Activity
		- helps traumatised women and provides legal advice.
	AKF e.V.	- professionals specialized around women's health (not only childbirth and pregnancy). - participates on political round tables. - writes reports for the government around women's health.
	Greenbirth e.V.	- advocates "natural", intervention-free childbirth. - offers info for families on their website.
DK	Mødrehjælpen	- provides information, support and advice to women, and parents.
EE	N/A	
EL	OVO Hellas	- only institution that has addressed openly the issue of obstetric violence in Greece. - raises awareness among women recipients of gynaecological or obstetric care.
	Project parenting	- a monthly subscription cost, which provides parenting educational material (videos, e-books, articles and online talks). - 12 online talks on obstetric violence among practitioners in the field of perinatal care. - awareness raising about women's rights. - 2-hour seminar on the prevention of obstetric violence and trauma with a cost of 25 euros.
ES	El Parto es Nuestro	- works for childbirth care that respects the wishes, needs and rights of mothers. - defends the autonomy and the leading role of women and a birth without unnecessary and/or dangerous interventions.
	PETRA Maternidades Feministas	- focus on motherhood. - promotes actions and policy initiatives from a feminist perspective.
	Obstetric Violence Observatory	- works to achieve maternity free of violence and discrimination for all women.
	Dona Llum	- works for dignified and respectful care during pregnancy, childbirth and postpartum. - observes health practices and demands their adaptation to scientific evidence while respecting the needs and rights of women and babies.
	Breastfeeding support associations[463]	- speak out against obstetric violence because of its consequences on breastfeeding.
	Nursing research group (Universitat Jaume I)	- has a specific line of research on "Pregnancy care, perinatal and child health" from where they promote research on obstetric violence.

[463] https://apilam.org/; https://www.federacion-matronas.org/

Country	Organisation	Activity
	Working group for the study and prevention of obstetric violence (GTepVO)	- works for the integral health of women, - reviews obstetric violence in a multifaceted, open and unprejudiced way. - deploys awareness-raising, training, research and prevention strategies in a cross-cutting and multidisciplinary manner. - creates synergies and a support network among professionals and to share the work carried out.
FR	Collectif Interassociatif autour de la Naissance - Ciane	- awareness raising and supporting women in the process of putting forward a complaint.
	Stop VOG	- the organisation records around 200 testimonies each month from women who consider themselves victims of obstetric and gynaecological violence. - asks for the inclusion of this violence in the law. - provides victims with support and information on available recourse. - has legal force with specialized lawyers who can inform victims.
	'The Women's Foundation	- provide legal information. - awareness raising material.
	The institute of research and action 'or women's health (Institut de Recherche et d'Action pour la Sante des Femmes)	- provides some information and legal support to women victims of obstetric and gynaecological violence.
IE	Association for the Improvements in Maternity Services Ireland (AIMSI)	- highlights normal birth practices, which are supported by evidence-based research and international best practices - campaign for recognition of maternal autonomy and issues surrounding informed choice and informed refusal for women in all aspects of the maternity services. - offers support and information on maternity choices and care to women and their families. - They assist in complaints and run a private online Birth Healing support group for women following difficult and/or traumatic birth. - They stay informed of key issues in maternity care and feedback directly to service providers, media, HSE and Government.
	The Irish Council for Civil Liberties (ICCL)	- the group focuses on access to abortion and not gynaecological or obstetric violence specifically[464].

[464] https://www.iccl.ie/?s=abortion

Country	Organisation	Activity
	The Abortion Working Group	- provides a space for information sharing and collective advocacy for groups working to ensure safe access to abortion in Ireland. - advocates for the provision of safe and effective access to a high-quality and comprehensive abortion care services.
HR	Roda	- awareness, support, training for women and health workers.
	SOS Rijeka	- awareness, support.
	PaRiTer	- awareness.
	Hrabre sestre	- support, especially for women seeking abortion services.
	Zaklada Solidarna	- awareness.
HU	Másállapotot	- refers to the need of a different state of affairs in maternity care.
	EMMA Association	- works for the fundamental rights and societal equality of women, paying special attention to gender-based oppression and violence against women during the childbearing and childrearing period.
	The igyszultem.hu	- site that collects the experiences of women who have given birth in a maternity institution in Hungary in the last ten years, with particular regard to the quality of the maternity care experienced and the practice of paying gratuities.
IT	**Observatory for obstetric violence** OVOItalia	- awareness raising. - research.
LT	Union of Obstetricians of Lithuania	- advising women. - training for medical professionals (obstetricians mostly). - awareness raising for public and medical professionals, advocacy, legislative initiatives.
	Association of Midwifes of Lithuania	
	Union of Maternity Care Initiatives	
LU	Platform JIF	- awareness raising.
LV	Manabalss.lv	- develops tools for digital democracy, promoting 'citizens' involvement in political decisions collected citizen votes and handled in the Parliament initiative "On the rights of pregnant women to free epidural anaesthesia ". It was approved in 2021 and funding was allocated to the procedure since August 2021.
MT	Women's Rights Foundation	- involved in the area of violence against women and adopted an intersectional approach to address

Country	Organisation	Activity
		it, campaigning in favour of women's reproductive rights.
NL	**Geboortebeweging**	- campaign. - activism to describe injustice in childbirth.
	Stichting Bevallingstrauma	- most renowned organization on birth trauma in the Netherlands. - has a long entry on obstetric violence as a cause of traumatic birth on their website.
PL	**Childbirth with Dignity Foundation**	- advocacy for women. - educating women about their rights - educational webinars, legal support, social campaigns engaging women to write complaints using a developed IT tool. - training for staff in respectful maternity care - conferences addressed to staff. - guard interventions in the event of violations of women's rights in hospitals. - legal support for victims of obstetric and gynaecological violence.
	The Matecznik Foundation	- webinars on women's rights. - psychological and legal support for women.
PT	**Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto**	- training for health professionals - campaigns
	OVO Portugal	- support - campaigns
	Associação Saúde das Mães Negras e Racializadas em Portugal (Samanepor)	- campaigns
	Portuguese Association of Obstetric Nurses	Ethical-Relational Skills Development Course in Maternal Health and Obstetric Nursing. - training discusses legal aspects in Maternal Health and Obstetric Nursing, women's rights during labour, birth and the postpartum period (in times of pandemic) and obstetric violence.
	Nascer com direitos	- has written a book to inform the general community on the rights during pregnancy and childbirth. - provides training for pregnant women/couples on pregnancy and childbirth issues, health professionals on the legal aspects of clinical practices, for midwives, and on the legal aspects of home births.
	UTERUS	- has a training for professionals that includes one topic (among a total of 9 topics) on the WHO guidelines for a positive experience of birth.

Country	Organisation	Activity
RO	FILIA centre	- documented and published a report on refusal to perform abortion on demand in public hospitals in Romania. - have done campaigns, collected testimonies of women, carried out research, published analysis and carried out advocacy work for changes in legislation and implementation of policies in obstetric and gynaecological violence.
	Mothers to Mothers	- aims to protect the rights of women to benefit from accessible and adequate care during pregnancy, at birth and after birth, as well as their right to human dignity during medical care. - raises awareness and formulated demands for legal and policy changes, including the term 'obstetric violence' to be addressed and stopped.
	The Independent Midwives Association in Romania	- opened first national helpline (AMI Youth Helpline) dedicated to young people (12 to 24 years, both women and men) for information and support for health and reproductive rights and combating gender-based violence.
SE	Birth rights Sweden	- brings awareness of women's rights in childbirth.
SI	Umbilica	- work on the topic of OB-GYN violence. - create resources for women/families. - collect stories. - put pressure on responsible organizations. - works on providing a tool for collection of patients' rights breach in maternity care.
	Pravice Porodnice	- launched a website informing people on rights in childbirth and proper care.
SK	Poradňa pre občianske a ľudské práva **(Consultancy for civil and human rights)**	- deals with discrimination against Roma women in Slovakia. - deals with the issue of involuntarily sterilised Roma women and Roma segregation in the healthcare.
	Asociacia na ochranu práv pacientov **(Association for the Protection of the Patient's Rights):**	- provides help to patients who are not satisfied with provided healthcare and assists them if they wish to file a complaint.
	Občan, demokracie a zodpovednosť **(Citizen, democracy and responsibility)**	- provides workshops raising women's legal awareness and they focus on disadvantaged women (from Roma minority).
	Ženské kruhy **(Women´s Circles):**	- advocates for respect, dignity and freedom of choice for women during pregnancy and childbirth.

Country	Organisation	Activity
FI	**Aktiivinen synnytys**	- a non-profit organization working on active agency and family-centered care.
	Synnyttäjien oikeudet ry	- raises awareness of legal and patient rights of all people giving birth.

Annex 2. Country case studies

A2.1 Belgium

Section I. Legal classification and access to justice[465]

1.1. Legal classification of obstetric and gynaecological violence and type of penalties

There is no specific legislation on obstetric and gynaecological violence, but the following legislation applies:

1) **Law of 22 august 2002 on patients' rights**

This legislation recognises a series of rights that are of the utmost importance in obstetric and gynaecological care: the right to quality services that meet their needs (art. 5); the right to information about their state of health and how it is evolving (art. 7); the right to free and informed consent to any intervention (art. 8); the protection of patients' privacy and respect for their intimacy (art. 10), the patients' right to the "most appropriate" care for pain (art. 11bis).

2) **Law of 22 April 2019 on the quality of healthcare practice**

This legislation requires healthcare professionals to "know precisely the limits of their competences" (*"connaître précisément les limites de leurs compétences*") and. in particular, to ensure that they have the necessary supervision to provide healthcare "at a high level of quality" (art. 14: "*avec un niveau de qualité élevé*"). Furthermore, when they provide high-risk services, healthcare professionals are obliged to ensure both an effective emergency procedure in the event of complications and a second procedure for transferring patients (art. 18). This is interesting in relation to birthing centres and, in this respect, the Senate Equal Opportunities Committee recommend in the information report adopted on 22 May 2023 to integrate or attach birthing centres to hospitals to promote compliance with these provisions.

3) Certain types of obstetric or gynaecological violence are likely to fall within the scope of the **criminal law**. For instance, abdominal expression could constitute "*coups et blessures involontaires*"' (unintentional blows and wounds, art. 418, Criminal code), while a health professional who sutures the perineum without anaesthetic after an episiotomy could be considered guilty of torture (art. 417-bis, Criminal code). See the opinion of the GAMS[466], which considers episiotomies performed without medical reason and procedures such as the 'husband's stitch' to be female genital mutilation (art. 409-bis, Criminal code). More generally, it should be noted that, in principle, attacks on physical integrity, whether intentional or not, could constitute a criminal offence (articles 398 et seq. and 418 et seq. respectively of the Criminal Code), also when performed in the healthcare sector. However, when the perpetrator can invoke an objective justification, whether an authorisation or a legal obligation, the act does not constitute a criminal offence. Consequently, most medical interventions carried out on patients are punishable under criminal law when there is a violation of the legal framework (e.g. a breach of Law of 22 August 2002). Other criminal provisions might apply to the activities of healthcare

[465] This section is entirely based on the information provided by the article Vers l'émergence de la problématique des " violences obstétricales et gynécologiques " dans la sphère politique et institutionnelle belge ?, written by Anne-Isabelle Thuysbaert and Jean-Marc Hausman and published in the Journal de droit de la santé et de l'assurance maladie, 2023, 37. Ffhal-04198796f and by the Information report adopted by the Advisory Committee for Equal Opportunities of the Senate (Rapport d'information du Comité d'avis pour l'égalité des chances du Sénat) on 22 May 2023.

[466] « GAMS » : Groupe pour l'abolition des mutilations sexuelles féminines.

professionals, particularly when there is no harm to the physical integrity of patients. This is the case, for example, of Law of 22 May 2014 designed to combat sexism in the public space, which could justify prosecution and conviction for, among other things, certain inappropriate comments or behaviour directed at female patients.

4) In **civil law**, healthcare professionals and institutions must respect any contractual obligations they may have[467]. They may also incur extra-contractual liability in the event of damage caused to others through their fault or that of persons for whom they are responsible[468].

As pointed out by the Senate Equal Opportunities Committee in the information report adopted on 22 May 2023 (see below), although this legal framework appears to be relatively complete - even if obstetric and gynaecological violence is not a specific subject of it, it is insufficiently known by a significant proportion of healthcare professionals and patients. This situation is, according to the information report, one of the factors explaining the lack of effectiveness of the above-mentioned legal framework[469]. For this reason, the Senate Committee insists on awareness-raising and training for different audiences[470].

1.2. Access to justice

There are a number of complaint mechanisms. However, as the Senate Committee observed in its report, patients rarely use them. In addition to ignorance of the legal framework referred to above, the information report points to their conviction that their likelihood of obtaining satisfaction through these procedures is limited[471].

1) **Mediation**. Patients have the right, established by Law of 22 August 2002, to lodge a complaint with the mediation service of the hospital concerned ("*plainte auprès de la 'fonction de médiation' de l'hopital*") or, failing this, with the mediation service of the Federal Commission for Patients' Rights (see art. 11). Recourse to mediation is voluntary for both parties. Moreover, in-hospital mediators are legally bound by a duty of confidentiality, neutrality and impartiality, imposed by the Royal Decree of 8 July 2003 laying down the conditions to which the mediation function in hospitals must conform. Nevertheless, patients have strong doubts about the independence of the procedure, given that they are employed by the healthcare establishments where the health professionals in question work[472]. While the Advisory Committee for Equal Opportunities of the Senate (*Comité d'avis pour l'égalité des chances du Sénat)*, considers that mediation can be a relevant tool for restoring communication in cases with "rather limited" physical consequences, it considers that this route is not very suitable for establishing liability or setting financial compensation in more serious cases[473]. Several of the

[467] It should be noted that in the case of a contractual relationship, in certain cases victims benefit from a "liability option" ("*option de responsabilité*"), allowing them to prefer the extra-contractual route. This is particularly the case when the breach of the contractual obligation also constitutes a criminal offence, which is not uncommon in healthcare.

[468] Article 1382 Civil code, defines the '*faute aquilienne ou délictuelle'* as « tout fait quelconque de l'homme, qui cause à autrui un dommage, oblige celui par la faute duquel il est arrivé, à le réparer ».

[469] Advisory Committee for Equal Opportunities of the Senate, Information report (*Rapport d'information du Comité d'avis pour l'égalité des chances du Sénat)*, 22 May 2023, pp. 9 et 11.

[470] *Rapport d'information*, op. cit., paras 35 - 38.

[471] Rapport d'information, ibid, p. 23.

[472] Rapport d'information, ibid, p. 23.

[473] Rapport d'information, ibid, p. 24.

recommendations are therefore aimed at improving the quality of these services and their credibility with patients[474].

With this in mind, one of the recommendations is that the general public should be better informed about this procedure, "in order to enable patients to speak out in complete confidence". The information report also stresses the importance of guaranteeing the independence of in-hospital mediators and ensuring a mediation process is fast set up. Finally, it should be noted that the Advisory Committee for Equal Opportunities of the Senate (*Comité d'avis pour l'égalité des chances du Sénat*) recommends the adoption of a legal basis and the definition of precise criteria enabling any mediator to attribute the status of obstetric and gynaecological violence t– a file - which should help to objectify both the phenomenon and its treatment[475].

2) **Disciplinary proceedings** before professional bodies - in particular the Belgian Board of Physicians (*Ordre des Médecins)*[476]. Doctors incur disciplinary sanctions when they breach the Code of Medical Ethics, which was reformed in 2018. However, during the hearings for the report, several experts have raised the problem of the composition of the councils of the Belgian Board of Physicians (*Ordre des Médecins)*, which does not guarantee its independence and impartiality[477], as it is almost exclusively made up of doctors. For more than a decade, there has been a succession of plans to reform this professional body, but none of them has come to fruition. In addition to re-examining the disciplinary procedure and its terms and conditions, the Advisory Committee for Equal Opportunities of the Senate (*Comité d'avis pour l'égalité des chances du Sénat*) suggests that, if necessary, the disciplinary penalties should be increased for serious offences or repeat offences[478].

3) **Criminal or civil proceedings** before the courts and tribunals. According to the information report, very few actions are brought and most of them are aimed at obtaining compensation for physical harm only[479]. One explanation for this is that the victims are convinced that they have little chance of success. This fear does not appear to be entirely unfounded, as the success rate of victims before the courts and tribunals is very low.[480] The Advisory Committee for Equal Opportunities of the Senate (*Comité d'avis pour l'égalité des chances du Sénat*) identifies a number of factors that could contribute to this situation. It emphasises the burden of proof in medical matters. In principle victims have to prove the fact, and this is a complex and onerous task, particularly when it comes to proving the causal link between the act and the harm[481]. This difficulty is in particular due to the fact that childbirth often involves a "cascade of acts"[482]. Furthermore, other factors could intervene[483]: the patriarchalism/sexism characteristic of

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474 *Rapport d'information*, recommendation no. 35, p. 37.

475 Rapport d'information, ibid, p. 13-14.

476 In the health sector, there are other professional orders, including that of psychologists - *the Commission des psychologues*.

477 Rapport d'information, ibid, p. 24.

478 *Rapport d'information*, recommendation no 36, p. 37.

479 Rapport d'information, ibid, p. 25.

480 Several experts maintained during the hearings that in Belgium, no patient had so far obtained recognition before the courts and tribunals of the violence of which she had been a victim (*Information report*, ibidem, p. 26).

481 Rapport d'information, ibid, p. 26.

482 The Senate committee gives as an example the case of an induction "which led to an episiotomy that could have been avoided without accelerating labour" *(Information report*, ibidem, pp. 26-27).

483 See Thuysbaert A. I., Hausman J. M., Vers l'émergence de la problématique des " violences obstétricales et gynécologiques " dans la sphère politique et institutionnelle belge ?. Journal de droit de la santé et de l'assurance maladie, 2023, 37. ffhal-04198796f.

contemporary Western societies, particularly in the legal[484] and medical[485] world. Not to mention, the pathologisation of childbirth and the trivialisation of medical interventions on patients' bodies[486].

4) Victims of obstetric and gynaecological violence may also apply to the Medical accidents funds (*Fonds des accidents medicaux)* created by Law of 31 March 2010 on **compensation for damage resulting from healthcare**. This compensation mechanism is innovative in that it makes possible, among other things, to obtain compensation for certain "sufficiently serious" injuries caused by a "no-fault medical accident" (art. 4 and 5)[487]. However, the victim still needs to demonstrate that there is a casual link between the harm and the medical negligence[488], which, as already mentioned, it is a heavy burden of proof.

Section II. Awareness and prevention

2.1. Awareness

On 1 April 2021, some twenty senators tabled a request for an information report on the right to bodily self-determination and the fight against obstetric violence. Voted on by a fairly narrow majority, the **Advisory Committee for Equal Opportunities of the Senate** (**"Comité d'avis pour l'égalité des chances du Sénat")** heard from just over twenty experts, mainly from the health sector, associations and academia. An **information report** was drawn up on this basis and **adopted by this body on 22 May 2023** - was submitted for discussion and vote to the plenary assembly of the Senate on 23 June. The Information Report focus on the right to bodily self-determination and the fight against obstetric violence. The report is the result of two years of work. It provides an overview of these types of violence in Belgium and their causes. It also puts forth ninety-two recommendations aimed at promoting a culture of kindness in gynaecology and obstetrics and combating these forms of violence[489].

The information report was not put to the plenary vote at the Senate session of the Senate on 23 June 2023. The Senate decided to refer it back to committee[490], following letters the two main associations of obstetricians and gynaecologists - one French-speaking (the Royal College of French-speaking obstetrician-gynaecologists of Belgium - Le Collège royal des gynécologues obstétriciens de langue française de Belgique – CRGOLFBVVOG) the other Flemish (Professional organisation of Flemish

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484 Bartlett K. T., Kennedy A. L., *Feminist Legal Theory: Reading in Law and Gender*, Londres, Routledge, 1991.

485 Harding S., *The Science Question in Feminism*, Ithaca, Cornell University Press, 1986; L. Schiebinger, Nature's Body: Gender in the Making of Modern Science, New Brunswick, Rutgers University Press, 1993.

486 M. Borges, *A violent Birth : Reframing Coerced Procedures during Childbirth as Obstetric Violence*, Duke Law Journal, 2018, pp. 839-840 ; P. Jassogne, Les violences gynécologiques et obstétricales : médecine et droit sous le prisme du genre, Faculté de droit et de criminologie, Université de Louvain, 2020 (prom. : J.-M. Hausman).

487 See Thuysbaert A. I., Hausman J. M., Vers l'émergence de la problématique des " violences obstétricales et gynécologiques " dans la sphère politique et institutionnelle belge ?. Journal de droit de la santé et de l'assurance maladie, 2023, 37. ffhal-04198796f

488 It is also necessary to prove the following elements: "the reality and extent of harm [;] the absence of any link with his or her own condition and its objectively foreseeable evolution [;] the circumstance that it is not a case of therapeutic failure [;] the abnormal nature of the harm experienced" (G. Génicot, Droit médical et biomédical, Bruxelles, Larcier, 2016, p. 534). See also G. Schamps, "Le Fonds des accidents médicaux et l'indemnisation des dommages résultant de soins de santé", Revue générale des assurances et des responsabilités, 2014, p. 15036.

489 All documents from Senate (including hearings) available here: https://www.senate.be/www/?MIval=/Dossiers/Informatieverslag&LEG=7&NR=245&LANG=fr

490 https://www.lesoir.be/523840/article/2023-07-05/violences-obstetricales-les-raisons-dun-blocage-au-senat

gynaecologists and obstetricians - *Vlaamse Verenonging voor Obstetrie en Gynaecologie* - VVOG)[491] . An amended report was recently adopted in February 2024.

The National Action Plan to fight gender-based violence 2021-2025 (*Plan D'action National De Lutte Contre Les Violences Basées Sur Le Genre 2021-2025***)** [492]

This NAP is based on the Council of Europe Convention on preventing and combating violence against women and domestic violence, known as the Istanbul Convention, and on the recommendations addressed to Belgium concerning the implementation of this Convention. It includes 201 measures relating to the federal State, Communities and Regions. The NAP recognises the existence of obstetric and gynaecological violence, and that the prevention of this violence is a necessity. The NAP foresees the creation of a federal working group (that will include professional associations and representatives of health ministers and departments) in order to develop a specific policy in this area. The NAP also makes reference to the information report (that at the time was being written up), as useful in defining the measures to be put in place.

At regional level, terminology being used in public discourses by regional governments is obstetric and gynaecological violence[493].

Gender equality Action plans that specifically mention gynaecological and obstetric violence

Intra-Francophone Plan to fight violence against women 2020-2024, from the French speaking regional entities (*Fédération Wallonie-Bruxelles, Région wallonne et de la Commission Communautaire Francophone*) identifies gynaecologic and obstetric violence as a new form of recognised violence. Its Operational objective 8 (and Measure 27) focuses on Prevention of gynaecological and obstetric violence[494]. The plan recognises the specific nature of this violence, and the need to improve awareness on this issue. It commits to fund initiatives carried out by CSOs to raise awareness on women/patients' rights, train healthcare professionals, strengthen collaboration between healthcare providers and CSOs working on this issue, and deliver specific training to obstetricians and gynaecologists on the issue of obstetric and gynaecological violence. A call for projects was launched in 2022 [495]. Measure 28 aims at strengthening soon-to-be mothers on their rights and on existing mechanisms. For this, the plan foresees actions to strengthen guidelines and training of public service providers who provide support to expecting mothers. Finally, measure 29 focuses on improving care received during abortion procedures through funding and implementation of training and awareness raising activities.

491 https://www.vvog.be/

492 https://igvm-iefh.belgium.be/sites/default/files/20211125-pan-2021-2025-clean-fr.pdf

493 https://www.rtbf.be/article/neuf-projets-contre-les-violences-gynecologiques-soutenus-par-les-entites-francophones-11102109

494 http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&g=0&hash=d8b3da0904b5dcdae4bcd11756362e9874c77921&file=fileadmin/sites/sdec_III/upload/sdec_III_super_editor/sdec_III_editor/documents/Violence/VF_Plan_intra_francophone_violences_2020-2024_01.pdf

495 http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&g=0&hash=66c1ecf07baff8d7fa9509f310d1fe80798eb254&file=fileadmin/sites/sdec_III/upload/sdec_III_super_editor/sdec_III_editor/documents/Droits_des_Femmes/Appel_a_projets_VOG_2022/Appel_a_projets_violences_gyneco_et_obst_DEF.pdf

Following the call for projects, nine projects were selected dealing with the implementation of training for professionals, the organization of awareness days, the creation of a video game on the theme of gynaecological violence or an awareness campaign addressing students.

The government of the *Fédération Wallonie-Bruxelles* - i.e. the French-speaking Community - recognises in its Women's Rights Plan 2020-2024 (*Plan Droits des Femmes* 2020-2024)[496] , adopted on 17 September 2020, the reality of obstetric and gynaecological violence. It also includes a whole series of measures aimed at preventing it. Two months later, on 26 November 2020, all the governments of the French-speaking federated entities[497] set themselves the same objective, adopting the Intra-Francophone plan to combat violence against women 2020-2024 (*Plan intra-francophone de lutte contre les violences faites aux femmes 2020-2024*)[498].

The Women's Rights Plan 2020-2024 of Fédération Wallonie-Bruxelles comprises a Measure (1.8.1) on Prevention of gynaecological and obstetric violence. Under this, the regional entity notes that objective and systematic information for young girls and women about their rights, their choices and their possibilities with regard to their bodies (consent to medical procedures, freedom of choice regarding contraception, etc.) must be reinforced in the within the framework of EVRAS activities in schools, interventions by Psycho-Medico-Social Centers (CPMS) and within the framework of Health Promotion at School (PSE)[499].

Organizations working on the issue and activities carried out

The **Citizen Platform for a Respected Birth** (*Plateforme citoyenne pour une naissance respectée*), founded in 2014, is a collective bringing together users, health professionals, associations and feminists. It recalls the right of women to choose the circumstances of their childbirth in the interest of newborns, mothers and their partners and wants obstetric violences to be recognised[500].

In 2020, **Women and Health** (*Femmes & Santé)* developed a feminist self-defence manual as part of sexual and reproductive health consultation with partner associations: "Areas to defend" This manual covers the violence and abuse that women can experience throughout life in the context of sexual and reproductive health consultations. It offers ways for women to defend themselves and assert their rights[501].

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496 *Fédération Wallonie-Bruxelles, Plan Droit des Femmes, Fédération Wallonie-Bruxelles*, 17 September 2020, available at : http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&g=0&hash=fba5f84be288ad0d20ffc7c6da00b8b6df5d46fa&file=fileadmin/sites/sdec_III/upload/sdec_III_super_editor/sdec_III_editor/documents/Droits_des_Femmes/Plan_Droits_des_Femmes_2020-2024_FWB.pdf

497 I.e. the governments of Fédération Wallonie-Bruxelles, of the Région wallonne and of the Commission communautaire française.

498 Fédération Wallonie-Bruxelles, Région wallonne et Commission communautaire française, Plan intra-francophone de lutte contre les violences faites contre les femmes 2020-2024, 26 November 2020, available at : http://www.egalite.cfwb.be/index.php?id=21146

499 http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&g=0&hash=fba5f84be288ad0d20ffc7c6da00b8b6df5d46fa&file=fileadmin/sites/sdec_III/upload/sdec_III_super_editor/sdec_III_editor/documents/Droits_des_Femmes/Plan_Droits_des_Femmes_2020-2024_FWB.pdf

500 https://www.naissancerespectee.be/

501 https://www.femmesetsante.be/ressources/zones-a-defendre/

The non-profit organization *Prémisse* (*L'ASBL Prémisse*) has created: "Don't touch my body without my consent" *("Touche pas à mon corps sans mon accord*"), a prevention guide against gynaecological and obstetric violence[502].

Initiative carried out in the Wallonia-Brussels Federation (*Fédération Wallonie-Bruxelles*) to collect women's voices and experiences on the issue

The Citizen Platform for a respected birth *(Plateforme citoyenne pour une naissance respectée*) led a research (questionnaire) in 2021 surveying 4,226 women[503]

The non-profit association Synergie Wallonie for equality between women and men launched a survey for women and girls: "Your Pain, Your Words on the subject of gynaecological and/or obstetric violence" (*Vos Maux, Vos Mots au sujet des violences gynécologiques et/ou obstétricales*)[504].

The collaborative site "Go to Gyneco" is the first in Belgium to offer a space for discussion for the lesbian community and to recommend lesbian friendly professionals[505].

These spaces help create a climate of trust free from any discrimination based on sexual orientation or identity, skin colour, weight and lifestyle choices.

Initiative targeting specific groups of women

Research been carried out to address issues in relation to obstetric and gynaecological violence faced by specific groups of women.

Racialised women

The regional survey carried out in 2021 by the Citizen Platform for a respected birth *(Plateforme citoyenne pour une naissance respectée*) showed that 1 in 5 women have been victims of this violence but that when they are racialized, the figure rises to 1 in 3 women.

Women with disabilities

The non-profit organizations Women and Health *(Femmes & Santé)*, Disability and Sexuality Resource Center (*Handicaps & Sexualités Centre de Ressource*) and Disability and Health *(Handicaps & Santé)* have published a report on gynaecological and obstetric violence (VGO) experienced by women with intellectual disabilities living in institutions[506]. This publication is the result of two years of interviews and analyzes with psychomedical-social professionals who support women with intellectual disabilities living in institutions. They recounted the gynaecological and obstetric violence experienced by these women, the obstacles to respectful care, the difficulty in respecting their consent and their choices. They put forward possible avenues for reflection and action to change practices and promote self-determination regarding their bodies. It uses data from previous studies to show increase rates of gynaecological and obstetric violence among women with disabilities.

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502 https://premisse.be/index.php/touche-pas-a-mon-corps-sans-mon-accord/#page-content

503 Plateforme citoyenne pour une naissance respectée, Accoucher en Belgique francophone avant et pendant le covid. Éléments clés de l'enquête, disponible à l'adresse suivante : https://www.naissancerespectee.be/wp-content/uploads/2022/02/PCNR-synthese-Rapport-2021.pdf

504 https://linfo-csc.be/magazine/negocier-collectivement-ou-supplier-collectivement/violences-gynecologiques-et-obstetricales-demande-de-temoignages/

505 https://gotogyneco.be/projet/

506 Violences gynécologiques et obstétricales vécues par les femmes avec une déficience intellectuelle vivant en institution : Étude exploratoire sur la situation en Belgique francophone. Available at : https://assets.ctfassets.net/10gk3lslb1u3/2vcluHLvfLz8ft5GYjhsrt/96a054afc2e4de6e2ceee73c485d1e3d/rapport_VGO-web.pdf

2.2. Prevention

The Professional organisation of Flemish gynaecologists and obstetricians (Vlaamse Verenonging voor Obstetrie en Gynaecologie VVOG) and the Royal College of French-speaking obstetrician-gynaecologists of Belgium (*Le Collège royal des gynécologues obstétriciens de langue française de Belgique - CRGOLFB)*) contests the definition given to obstetric and gynaecological violence, and the figures reported in several studies. Both associations are very opposed to the Senate report adopted on February, despite the amendments to the text following a letter from these two associations. The VVOG declared the term 'obstetric violence' to be unacceptable and sent a very strong message against midwifes replacing gynaecologists, even if only in low-risk obstetric cases[507].

The VVOG decided even to terminate any collaboration with the Federal Belgian Health Care Knowledge Centre (*Federaal Kenniscentrum voor de Gezondheidszorg* - KCE) for the revision of the 2010 guidelines[508] 'Good clinical practice in low-risk childbirth' (*Goede klinische praktijk bij laagrisico bevalling*), prepared by a midwife-led group under a project[509] funded by the Federal Health Public service (*FOD Federale Overheidsdienst Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu*)[510] and refused cooperation in the development of a quality label for midwifes, initiated by the Federal Health Public service (*FOD Federale Overheidsdienst Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu*)[511]

Some hospitals have developed guidelines and commitments to respectful care, such as Obstetric well-treatment charters (e.g. *Charte de soins du CHU de Liege*)[512].

To complement desk research[513], interviews were conducted with the following persons to discuss the implementation of the Intra-Francophone Plan to fight violence against women 2020-2024 *(Plan intra-francophone de lutte contre les violences faites aux femmes 2020-2024)*:

Sylvie GROLET, Region Wallone; Deborah Kupperberg, Federation Wallonie Bruxelles; and Evelyne Verschueren, French Community Commission (*Commission communautaire française de la région de Bruxelles-Capitale, COCOF*)[514]

A2.2 Spain

Section I. Legal classification and access to justice

1.1 Legal classification of obstetric and gynaecological violence

In Spain there is no specific legislation on gynaecological and obstetric violence at state level, although some legislation can be highlighted, including:

[507] https://mailchi.mp/d1fedf7e538f/reactie-vvog-op-informatieverslag-senaat-respectvolle-kraamzorg

[508] https://kce.fgov.be/sites/default/files/2021-11/KCE_139A_richtlijn_laag_risico_bevalling.pdf

[509] https://www.ap.be/project/kce-richtlijn-bevalling

[510] https://www.health.belgium.be/nl

[511] https://www.health.belgium.be/nl

[512] https://www.chuliege.be/jcms/c2_23983670/gynecologie-obstetrique/bientraitance-obstetricale

[513] The Belgian case study focuses on Belgium as a whole. We were not able to identify any specific initiatives by the Flemish community to tackle obstretic and gyneacological violence.

[514] IT has to be noted that all interviews were carried out in the French Community of Belgium

- Law 41/2002 of 14 November 2002, the basic law regulating patient autonomy and the rights and obligations regarding clinical information and documentation[515]. This law was praised by the Council of Europe as a good example.
- Organic Law 3/2007, of 22 March, for the effective equality of women and men[516], which does not mention gynaecological or obstetric violence but does highlight in Article 8 discrimination on the grounds of pregnancy or maternity.
- Organic Law 1/2023, of 28 February, which modifies Organic Law 2/2010, of 3 March, on sexual and reproductive health and the voluntary interruption of pregnancy[517]. In May 2021, the Ministry of Equality announced that, within the reform of the 'abortion law', it would also address obstetric violence as a form of violence against women. Indeed, as shown in the initial debates, the possibility of including obstetric violence in the scope of this law was contemplated at inception stage[518]. However, despite amendments from different political groups and social support for such inclusion, the concept of obstetric violence was left out of the law and replaced by new concepts such as "*Appropriate gynaecological and obstetric interventions*" and "*Violence against women in the reproductive field*".

  It is also necessary to highlight that some Autonomous Communities include obstetric violence in their legislation. Those include:

- The Autonomous Community of Catalonia, which incorporated "obstetric violence and violation of sexual and reproductive rights" as a type of male violence in its legislation, being the pioneer community in doing so[519];
- The Valencian community, that has included the term in its health law; and
- The Autonomous Community of the Basque Country, which also assimilates it as a form of male violence in its law for equality of women and men[520].

In addition, in December 2022, the autonomous community of the Canary Islands approved a proposition of law for the regulation of obstetric violence.

This case study looked at the inclusion of obstetric violence in the legislations of two of those Autonomous Communities to shed a light on the different ways to frame this issue:

Framing obstetric and gynaecological violence under violence against women: the example of Catalonia

[515] Ley 41/2002, de 14 de noviembre, básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica: https://www.boe.es/buscar/act.php?id=BOE-A-2002-22188

[516] Organic Law 3/2007, of 22 March 2007 (*Ley Orgánica 3/2007, de 22 de marzo, para la igualdad efectiva de mujeres y hombres*), https://www.boe.es/buscar/act.php?id=BOE-A-2007-6115

[517] Organic Law 1/2023, of 28 February 2023 (*Ley Orgánica 1/2023, de 28 de febrero, por la que se modifica la Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo*), https://www.boe.es/buscar/doc.php?id=BOE-A-2023-5364

[518] *Conversatorio 3. Propuestas para erradicar la violencia obstétrica del sistema sanitario*: https://www.youtube.com/watch?v=z185iKRJHrE

[519] Law 17/2020, of 22 December (*Ley 17/2020, de 22 de diciembre, de modificación de la Ley 5/2008, del derecho de las mujeres a erradicar la violencia machista*), https://www.boe.es/buscar/doc.php?id=BOE-A-2021-464

[520] Law 1/2022, of 3 March (*Ley 1/2022, de 3 de marzo, de segunda modificación de la Ley para la Igualdad de Mujeres y Hombres*), https://www.boe.es/buscar/doc.php?id=BOE-A-2022-4849

As mentioned above, Catalonia is one of the few Autonomous communities that has included the fight against obstetric violence and the violation of sexual and reproductive rights in its legal framework. In 2020, the Catalan Parliament amended the Catalan law against gender-based violence (Law 17/2020, of 22 December, amending Law 5/2008, on the right of women to eradicate gender-based violence) to expand the scope and forms of violence legally recognised, as well as potential victims (the law now including girls and transgender women).

The 2020 legislative amendment, promoted by an alliance of left-wing parties and feminist groups, was initially aimed at including institutional violence and digital violence, and to update the law in accordance to the Istanbul Convention. However, during the hearings, feminist associations and academics raised the need to broaden the scope of the reform to include other forms of gender-based violence, including obstetric violence. Such suggestions were supported by the members of the Equality Commission, and the Parliament approved the section of Law 17/2020 that pertained to obstetric violence and violation of sexual and reproductive rights with a large majority of 130 votes in favour, five against, and no abstentions[521], recognising obstetric violence and the violation of sexual and reproductive rights as forms of violence against women. The 2020 law also recognised that in addition to intimate relationships, at home, and at the workplace, women can also experience violence in educational settings; political and public spaces (including digital spaces), as well as in institutional spaces.

The 2020 legislative amendment (Article 4.d) defines obstetric violence and a violation of sexual and reproductive rights as follows:

"*This consists of preventing or hindering access to reliable information which is necessary for independent and informed decision-making. It can have an impact on various areas of physical and mental health, including sexual and reproductive health, and can prevent or hinder women from making decisions about their sexual practices and preferences and about their reproduction and the conditions under which it takes place according to the situations included in the applicable sectoral legislation. It includes forced sterilisation, forced pregnancy, impeding abortion in the legally established cases, hindering access to contraceptive methods, methods for the prevention of sexually transmitted diseases and HIV and to assisted reproduction methods and also gynaecological and obstetric practices which do not respect women's decisions, bodies, health and emotional processes*".

This definition emphasises the issue with the lack of informed consent, which is understood as the obstacle or difficulty in accessing adequate and accurate information necessary for making independent and well-informed choices related to matters impacting sexual and reproductive health. The violation of sexual and reproductive rights, as practices that can be carried out by public employees, would constitute an expression of institutional violence, an area that Law 17/2020 covers with the following definition (article 5.6):

"*Actions and omissions of the authorities, public personnel and representatives of any public body or institution whose purpose is to delay, hinder or prevent access to public policies and the exercise of the rights recognised by this Act to ensure a life free of sexist violence in accordance with the situations included in applicable sectoral legislation. Any lack of quantitative and qualitative due diligence in tackling sexist violence constitutes a manifestation of institutional violence if it is known about or promoted by the*

[521] However, in April 2021, the Parliamentary Group of the Popular Party in the Congress of Deputies filed an appeal of unconstitutionality against several articles of the law. The text discusses the proposed changes to the law, including the inclusion of girls and transgender women, the definition of sexual consent (similar to the one in Organic Law 10/2022), the expansion of forms of violence (including obstetric violence), and the establishment of protocols for action against sexual harassment and other forms of sexist violence by political parties. The Constitutional Court admitted this appeal for processing, but it has not yet been resolved.

authorities or becomes a pattern of repeated and structural discrimination. This violence can stem from a single serious act or practice, from the repetition of acts or practices of lesser scope that generate a cumulative effect, from the failure to act when there is awareness of the existence of a real or imminent danger, and from re-victimising practices or omissions. Institutional violence includes law-making and the interpretation and application of law intended to bring about or resulting in the same outcome. The use of parental alienation syndrome is also institutional violence".

The law has introduced a precise definition of due diligence (Article 3.h): "*the obligation of the public authorities to adopt legislative and other measures so as to take action with the requisite speed and efficiency and ensure that authorities, staff, officials, public entities and other actors working on behalf of these public authorities comply with this obligation in order to appropriately prevent, investigate, prosecute, punish and redress acts of sexist violence and protect the victims*".

The Catalan legislative framework is a pioneer in Europe due to its incorporation of obstetric violence and the violation of sexual and reproductive rights, going even beyond the Istanbul Convention framework.

Framing obstetric and gynaecological violence under health: the example of the Valencian community

The Valencian community has incorporated the concept of obstetric violence in its Health Law[522], recognising women's rights in the area of sexual and reproductive health and aiming at implementing measures to combat obstetric violence, as defined by the World Health Organisation (WHO).

While Catalonia's Parliament chose to introduce obstetric violence within its law on violence against women, Valencian's Parliament discarded this option (which was the initial one in November 2021, but the inclusion of the term "obstetric violence" in the Integral Law against violence against women in the Valencian Community faced strong opposition[523,524,525]) and introduced obstetric violence in the Health Law (through the approval of Law 7/2021 of 29 December on fiscal, administrative and financial management and organisational measures of the Generalitat 2022[526], which amended Law 10/2014 of 29 December). The rationale behind such decision was that obstetric violence could not only be restricted to violence against women with a mere definition, but should be transversally addressed, especially due to the consequences it can have on women's health. This rationale was also aligned with what had been announced by the Spanish central government, which planned to include obstetric violence in the framework of a health law, such as the reform to the law on sexual and reproductive health and the voluntary interruption of pregnancy (Abortion Law).

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522 Law 10/2024, of 29 December 2024 (*Ley 10/2014, de 29 de diciembre, de Salud de la Comunitat Valenciana*), https://www.boe.es/buscar/pdf/2015/BOE-A-2015-1239-consolidado.pdf

523 Violencia obstétrica: el término de la discordia: https://www.levante-emv.com/cv-semanal/2022/01/09/violencia-obstetrica-termino-discordia-61383349.html

524 Indignación entre las sanitarias valencianas por legislar la "violencia obstétrica" como "machista": https://www.elespanol.com/alicante/vivir/salud/20211123/indignacion-sanitarias-valencianas-legislar-violencia-obstetrica-machista/629187759_0.html

525 La presión de los ginecólogos paraliza la consideración de la violencia obstétrica como machista en la ley valenciana: https://www.eldiario.es/comunitat-valenciana/politica/presion-ginecologos-paraliza-consideracion-violencia-obstetrica-machista-ley-valenciana_1_8539892.html

526 Ley 7/2021, de 29 de diciembre, de la Generalitat, de medidas fiscales, de gestión administrativa y financiera y de organización de la Generalitat 2022 (2021/13105). DOCV 9246. 30/12/2021

It is worth mentioning that prior to the modification of the Valencian Health Law, the political party COMPROMÍS registered a non-legislative proposal (number X041547) on 29th September 2021in the Valencian Parliament, which stated the following:

"*The Cortes urge the Consell de la Generalitat to urge the Spanish Government to include in the reform of the Law 2/2010, of 2 March, on sexual and reproductive health and the voluntary interruption of pregnancy (Abortion Law), the recognition of obstetric violence as a form of violence against women, as well as mechanisms to eradicate it*"[527].

This non-legislative proposal was approved by the Parliament in the ordinary plenary session of 24 and 25 November 2021 and it contributed to putting obstetric violence on the legislative but also societal agenda of the Valencian Community. Indeed, several press releases against such legislation were published by a sector of the medical community, while CSOs supporting pregnant women and new mothers (El Parto es nuestro[528] or Amamanta[529]) and the Midwife association of the Valencian Autonomous Community made statements and showcased interviews in favour of its adoption.

Finally, a change in the original wording of the amendment in favour of the legislation that would include obstetric violence within the Valencian health law opened the door to a political agreement. Law 7/2021 of 29 December (Law of measures) in its Chapter II, Section 3, Article 74 included the following wording:

"*Law 10/2014 on Health of the Valencian Community is amended, specifically a paragraph is added to Article 59 bis, paragraph 1, and a new letter b is created, reordering the following letters, with the following text: b) to guarantee measures tending to combat obstetric violence defined according to the World Health Organisation.*"[530]

1.2 Administrative and/or criminal penalties foreseen in cases of obstetric and gynaecological violence

Although the Spanish legislation does not address obstetric and gynaecological violence, the Law for the effective equality of women and men[531] does address discrimination on the grounds of pregnancy or maternity. Article 10 of Law 3/2007prohibits discriminatory conduct, and establishes a framework

[527] Original Text: "Las Cortes instan al Consell de la Generalitat a instar al Gobierno del estado español a incluir en la reforma de la Ley Orgánica 2/2010, de 2 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo (Ley del Aborto) el reconocimiento de la violencia obstétrica como un tipo de violencia que se ejerce sobre las mujeres, así como mecanismos para erradicarla"

[528] El Parto es Nuestro, Comunicado de El Parto es Nuestro sobre las recientes dimisiones en torno a la inclusión del término violencia obstétrica en la legislación de la Comunidad Valenciana (24/11/2021) https://www.elpartoesnuestro.es/blog/2021/11/24/comunicado-sobre-la-legislacion-de-la-violencia-obstetrica-en-la-comunidad-valenciana

[529] AMAMANTA, Violencia obstétrica y el inicio de la lactancia. 17/11/2021 https://amamanta.es/2021/11/violencia-obstetrica-y-el-inicio-de-la-lactancia-taller-tematico-online/

[530] Original text: "Se modifica la Ley 10/2014 de Salud de la Comunidad Valenciana, en concreto se añade un párrafo al artículo 59 bis, apartado 1, y se crea una nueva letra b, reordenando las siguientes letras, con el siguiente texto: b) a garantizar las medidas proclives a combatir la violencia obstétrica definida según la Organización Mundial de la Salud."

[531] Ley Orgánica 3/2007, de 22 de marzo, para la igualdad efectiva de mujeres y hombres: https://www.boe.es/buscar/act.php?id=BOE-A-2007-6115

for real, effective, and proportionate reparations or compensation, aimed at preventing discriminatory actions.

On the other hand, some forms of obstetric and gynaecological violence might constitute sexual violence and be covered by some legislation. Article 53 of Law 10/2022, of 6 September, on the comprehensive guarantee of sexual freedom[532]establishes compensation for physical and psychological damage, including moral damage and damage to dignity; loss of opportunities; material damage and loss of income; social damage; and therapeutic, social and sexual and reproductive health treatment. Law 41/2002[533] envisages a sanctioning regime that is foreseen in the General Health Law 14/1986[534]. However, the application of those laws to obstetric and gynaecological violence seems limited and difficult.

Furthermore, despite the fact that obstetric violence is regulated in three autonomous communities and that in two of them it is recognised as a form of gender violence, obstetric violence is not recognised as a form of gender violence by the Law 1/2004, of 28 December, on Comprehensive Protection Measures against Gender Violence[535], and the comprehensive protection measures established by the law cannot be applied to it.

Finally, Law 1/2023, of 28 February, which modifies Law 2/2010, of 3 March, on sexual and reproductive health and the voluntary interruption of pregnancy[536], determines among its objectives (article 5) the prevention, punishment and eradication of any form of violence against women in relation to health, sexual and reproductive rights. Article 24 states that the public administrations shall take comprehensive and effective measures to prevent, protect, investigate, punish and redress violations of women's sexual and reproductive rights.

1.3 Access to justice

In Spain, complaint mechanisms are different for public and private healthcare sectors.

Extra-judicial remedies against the public health care sector can be accessed, such as through complaints to the user service, requests for improvement to the quality of services of the health departments, complaints to the medical and nursing ethics committees and claims for financial liability of the health administration. In addition, if these channels result in rejection, silence or an unsatisfactory response, mediation by the Ombudsman can be requested. By judicial means, ordinary administrative litigation, civil liability claims against the administration's insurer and criminal proceedings against the actions of doctors and midwives can be applied.

If the intention is to denounce private health care, extrajudicial remedies include a complaint to the clinic's and the insurer's customer service department, a complaint to the inspection services of private health care centres, and a complaint to the doctors' and nurses' ethics committees. If the response is unsatisfactory, a complaint can be lodged with the Directorate General of Insurance and Pension Funds

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[532] Ley Orgánica 10/2022, de 6 de septiembre, de garantía integral de la libertad sexual: https://www.boe.es/buscar/act.php?id=BOE-A-2022-14630

[533] Ley 41/2002, de 14 de noviembre, básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica: https://www.boe.es/buscar/act.php?id=BOE-A-2002-22188

[534] Ley 14/1986, de 25 de abril, General de Sanidad: https://www.boe.es/buscar/act.php?id=BOE-A-1986-10499

[535] Ley Orgánica 1/2004, de 28 de diciembre, de Medidas de Protección Integral contra la Violencia de Género: https://www.boe.es/buscar/act.php?id=BOE-A-2004-21760

[536] Ley Orgánica 1/2023, de 28 de febrero, por la que se modifica la Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo: https://www.boe.es/buscar/doc.php?id=BOE-A-2023-5364

and/or the insurance policy can be cancelled. In the courts, there are civil liability and criminal proceedings against the actions of doctors and midwives.

Despite the existence of these channels, in Spain it is not possible to formally lodge a complaint for 'obstetric and gynaecological violence' and, instead, such incidents are typically categorised as "malpractice". However, as noted by the CEDAW committee in its resolutions against Spain[537, 538, 539], legal responses to malpractice complaints during obstetric care have tended to be marred by stereotypical representations related to women's health."

Indeed, there is a widespread feeling among women that accessing redress mechanisms, when they have just become mothers, is too difficult. As a result, women often do not act, or do not even know how to act.

Institutionally, Catalonia is the only autonomous community that, since 2022, has been monitoring complaints related to obstetric violence and, although it is not possible to know the number of complaints filed, it is possible to know that one out of four complaints are related to lack of information and 20% to issues in relation to care received during pregnancy and childbirth[540].

Complaint mechanism in Catalonia

The Catalan Department of Health, through the Catalan Health Service (*Servei Català de Salut*) has developed a mechanism for collecting all existing complaints related to healthcare. The service carries out a qualitative analysis of the content of the complaints that involves reading and classifying them by thematic areas. In application of Law 17/2020, of 22 December, on the modification of Law 5/2008, on the right of women to eradicate violence against women[541], the thematic areas now include new coding related to obstetric violence and the violation of sexual and reproductive rights, and to qualitative aspects of sexual and reproductive care.

Citizens can lodge a complaint directly at the healthcare facility, but they can also go to the central services or write a letter. If the complaint has been made at a specific facility, for example, at a primary care health centre, this complaint is passed on to the regional and then to central services, so that all complaints that enter the system end up at central services, where they are counted and dealt with. This makes it possible to know where (including in which care unit) and when the incident occurred and to which thematic area the complaint is related, but also to which thematic areas most incidents relate to. It is important to highlight that in addition to obligation for the administration to provide a response to the complainant, the response must be restorative and, if possible, a solution should be offered. The first investigation determines whether the complainant needs a response; a second opinion; or even additional care to remedy to harm. In the case of a medical malpractice, the medical inspection mechanism can be activated.

These complaints only include those that occur in the system as a result of sub-optimal care in the health system. However, citizens can also write to the Ombudsman and the Ombudsman may demand further information. Complaints to the Catalan Ombudsman are also counted, but not classified. On some occasions, women may write to the Ombudsman (*Síndic de Greuges*) but not file a complaint with the health system. There is another established mechanism called Transparency Mailbox (*Bústia de Transparencia*) that can be triggered by the Catalan Ombudsman when the response offered by the

537 CEDAW/C/75/D/138/2018: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/75/D/138/2018&Lang=en

538 CEDAW/C/82/D/149/2019: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2f82%2fD%2f149%2f2019&Lang=en

539 CEDAW/C/84/D/154/2020: https://digitallibrary.un.org/record/4008329

540 Pending publication.

541 Modification of the annex and instruction 03/2004, complaints and suggestions, of the Catalan Health Service: https://catsalut.gencat.cat/ca/detalls/articles/resolucio-2022-instruccio-03-2004

administration is not satisfactory. In this case, a mediation between the woman and the responsible agents takes place to reach a consensus on a measure. This last mechanism is also accounted for. Citizens should be aware of the possibility to lodge a complaint with the Ombudsman and the Transparency Mailbox; however, it is not the case though all the information is public.

Women face significant obstacles when trying to access these mechanisms. These barriers include limited awareness or insufficient resources, such as financial constraints. In addition, they face institutional violence, which manifests itself in discouragement or outright disincentive to file complaints or claims with the services concerned. The pervasive belief that their efforts will be in vain further compounds these challenges.

In addition, accessing complete clinical documentation is difficult. Women typically do not receive their complete records, and even when they do, critical interventions or procedures, such as the Kristeller manoeuvre, may not be mentioned. In addition, the partogram, a crucial tool for monitoring the progress of labour, is often insufficiently completed.

It is often through associations that women access information and receive support in the complaint process. Among the alternative spaces for reporting, those created by support groups and feminist women activists to protect and care for women victims can be highlighted. These include *El parto es nuestro*, *Observatorio de Violencia Obstétrica*, *PETRA Maternidades Feministas* or *Dona Llum*. The social networks of these associations also serve to make some cases visible by enabling women to expose their stories. The "me too" phenomenon is remarkable when a story of obstetric and gynaecological violence is exposed on social media.

Section II. Awareness and prevention

2.1 Organisations working to raise awareness

Among the existing associations and organisations working to raise awareness on the issue, the following can be mentioned:

- **El Parto es Nuestro**, whose aim is to work for childbirth care that respects the wishes, needs and rights of mothers, fathers and babies, aiming for a birth free of violence. They defend the autonomy and the leading role of women and a birth without unnecessary and/or dangerous interventions. The *El Parto es Nuestro* produced a report on care during childbirth in Spain during COVID-19, in which it highlighted having received a large number of complaints and concerns from women and midwives about the violation of women's rights during childbirth as a result of the pandemic[542]. They highlighted that the most frequent complaints were related to a lack of accompaniment, mother's separation from their newborn, the use of birth masks, induction and elective c-section and interventions to speed up labour (oxytocin and instrumentation).

- **PETRA Maternidades Feministas**, whose focus is more on motherhood, but it promotes actions and policy initiatives from a feminist perspective on pregnancy, childbirth and breastfeeding.

- **Obstetric Violence Observatory** works to achieve a maternity free of violence and discrimination for all women.

- **Dona Llum**, whose aim is for women and their children to receive dignified and respectful care during pregnancy, childbirth and postpartum in Catalonia. Its mission is to place women and their children at the centre of perinatal care in Catalonia, observing health practices and demanding their adaptation to scientific evidence while respecting the needs and rights of women and babies.

- **Breastfeeding support associations**. In Spain there are many breastfeeding support associations that also speak out against obstetric violence because of its consequences on breastfeeding.

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[542] Asociación El Parto es Nuestro, *Atención al parto en España y Covid-19*. Available at: https://www.elpartoesnuestro.es/sites/default/files/recursos/documents/infome_atencion_al_parto_y_covid_19_epen.pdf

- **Nursing research group (Universitat Jaume I)** has a specific line of research on "Pregnancy care, perinatal and child health" from where they promote research on obstetric violence.

- **Working group for the study and prevention of obstetric violence (GTepVO)**. This group has been created by the Catalan Society of Obstetrics and Gynaecology with the ethical commitment to work for the integral health of women, showing its willingness to gather and generate consensus regarding this reality; as well as to review obstetric violence in a multifaceted, open and unprejudiced way, deploying awareness-raising, training, research and prevention strategies in a cross-cutting and multidisciplinary manner.

The different activities carried out by this working group include the promotion of the rights of users and patients of the healthcare system, support for women through the creation of different groups and meetings, dissemination through the creation of materials to raise awareness, social networks, talks, workshops and seminars, and training and research aiming at improving the quality of health care services.

Initiative carried out to collect women's voices and experiences on the issue

Several examples of initiatives aiming to collect women's voices and experience, while also informing them about their rights were initiated by CSOs. Those include examples such as:

- El Parto es Nuestro and Dona Llum collect testimonies on their blogs, social networks and via email.
- *VOCES* is a Documentary Dance piece that talks about how Obstetric Violence is affecting millions of women in Spain. https://proyectovoces.es/
- *Vulnerables* uses photography as a tool to denounce and promote social change on obstetric violence. https://vulnerables.info/
- *El útero nimio*: Theatre play. https://www.elpartoesnuestro.es/blog/2022/01/10/el-utero-nimio-en-fuenlabrada
- *Anatomía de una sirena*: Theatre play. https://teatrodelbarrio.com/anatomia-de-una-sirena/
- *La Confiança*: Theatre play. https://www.lamutant.com/portfolio-item/la-confianca-sala-ultramar-2/
- *Parir en el Siglo XXI*: documentary web. https://lab.rtve.es/webdocs/parto-respetado/
- *Parir en el siglo XXI*: podcast. https://parir.info/
- *Radiojaputa*: podcast. https://radiojaputa.com/podcast/radiojaputa-42-violencia-obstetrica-la-violencia-que-no-existe/
- *Silenciadas*: voces contra la violencia obstétrica. Podcast. https://podcasters.spotify.com/pod/show/silenciadasvocescontravo

Public institutions' awareness and of the issue (e.g. government, Parliament, women's machinery)

The problem of obstetric violence has been highlighted and addressed in Spain, especially by social and feminist associations for years. It is likely that the term was first used by activists in the mid-2010s.

For activists, the publication of the UN Special Rapporteur's report was an important turning point[543]. It made possible to voice demands to public institutions to address the issues at stake. Following this report, several political groups started working for the inclusion of the issue of obstetric violence on the political agenda.

In 2023, Catalonia adopted the **Plan to tackle Obstetric Violence and Violations of Sexual and Reproductive Rights (2023-2028)[544]**.

Sexual and reproductive rights, which are human rights, occupy a central place in the political agenda of the Government of Catalonia. Their promotion and defence are a constituent part of the feminist transformation axis of the Government Plan 2021-2025.

The Government Plan includes the National Strategy for Sexual and Reproductive Rights, which is co-led by the Catalan Ministries of Equality and Feminisms and Health. The Strategy has an interdepartmental commission with participation from all 14 ministries of the Government of Catalonia. The commission is chaired by Equality and Feminisms. One of the Strategy's objectives is to eradicate obstetric violence and violations of sexual and reproductive rights. This is in line with numerous resolutions approved by multilateral organizations in recent years.

Following Resolution 2306 (2019) of the Parliamentary Assembly of the Council of Europe, to act transversally from health policies and equality policies to eradicate this form of gender-based violence, the Catalan Ministries of Health and Equality and Feminisms set up an institutional working group in December 2022 to address obstetric violence and the violation of sexual and reproductive rights through an Action Plan. The group included experts in gender and health, representatives of the Catalan Association of Midwives, the Catalan Society of Gynaecology and Obstetrics, the Health and Gender Advisory Council of the Catalan Ministry of Health and the two existing hospital commissions on obstetric violence in Catalonia.

This group met on a monthly basis with three basic objectives. The first was to produce a report on the legal framework, scientific literature and existing recommendations regarding the approach to obstetric violence and sexual and reproductive rights. This was accompanied by a historical contextualisation of the development of the model of care in Catalonia. Secondly, an analysis of the current situation in Catalonia was carried out, to understand the perceptions of both users and professionals involved, as well as to identify possible sources of information and generate a proposal for indicators. Finally, the group proposed tools to combat obstetric violence and the violation of sexual and reproductive rights, aimed at healthcare services and individual professional practices, citizens and organisations defending sexual and reproductive rights.

A year later, in December 2023, the Catalan government approved the Plan to tackle Obstetric Violence and Violations of Sexual and Reproductive Rights (2023-2028)[545]. This is a pioneering plan at global level, in line with the standards set by the World Health Organisation (WHO). The plan is structured around four axes, has nine strategic objectives and 56 actions. It is a very detailed plan with a specific timeline and a budget of 7 million euros. It aims to increase awareness and information on sexual and reproductive rights, to improve education and training, and to improve care and support services.

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[543] Enfoque basado en los derechos humanos del maltrato y la violencia contra la mujer en los servicios de salud reproductiva, con especial hincapié en la atención del parto y la violencia obstétrica: https://documents-dds-ny.un.org/doc/UNDOC/GEN/N19/213/30/PDF/N1921330.pdf?OpenElement

[544] Pla per a l'abordatge de la violència obstètrica i la vulneració dels drets sexuals i reproductius (2023 – 2028)

[545] The Plan is available at: https://scientiasalut.gencat.cat/bitstream/handle/11351/10977/pla_abordatge_violencia_obstetrica_vulneracio_drets_sexuals_reproductius_2023_2028_2023.pdf?sequence=1&isAllowed=y

The press release is also available in English: https://govern.cat/salapremsa/notes-premsa/568282/the-catalan-government-launches-pioneering-plan-in-europe-to-tackle-obstetric-violence-and-the-violation-of-sexual-and-reproductive-rights

The plan should ensure that the quality of the healthcare system improves, putting an end to inappropriate, routine or non-consensual procedures. For this reason, the plan includes, among other aspects, the creation of Obstetric Violence Commissions in all the health regions of Catalonia, with mechanisms for identifying, reporting and redressing cases of obstetric violence and violations of sexual and reproductive rights. The plan also includes measures to reduce caesarean sections and non-medically justified interventions, to promote women's participation in decision-making and improve access to reproductive health care. It also aims at providing spaces for maternity care in non-medical settings and increasing the number of maternity centres. It also includes actions targeted at specific groups, such as promoting the progressive adaptation of spaces and resources needed to care for people with disabilities or who are neurodivergent.
This plan aims to be a transformative tool for both citizens and health professionals, with a particular focus on identifying and disseminating good practices for respectful, rights-based care. It therefore includes public awareness campaigns and an ambitious training plan for professionals, including a specific module on sexual and reproductive rights, as well as specialised training on various topics such as improving early diagnosis of endometriosis, contraceptive care, voluntary abortion, trans* health, perinatal mental health and perinatal loss support. The Plan includes performance indicators for the planned actions and impact indicators. They are all published in the Plan document, which is open to public consultation[546]. In addition, an institutional monitoring mechanism is established to supervise and evaluate its implementation, through the Interdepartmental Commission of the National Strategy for Sexual and Reproductive Rights.

It should be noted that the Plan also incorporates recent data from surveys carried out during the Plan's development, which were directed at women, health professionals and organisations working with vulnerable groups. At the same time, it undertakes to develop, through specific actions, periodic surveys on obstetric and gynaecological violence among specific groups and the population in general, to detect the interrelationship of this violence with other areas of discrimination or the evolution of the perception and knowledge of society and the health sector itself about this type of violence.

Example of initiative targeting specific groups of women

Quantitative academic studies show that some groups of women are more at risk of experiencing verbal and physical violence during their obstetric care, and those include younger women, with secondary education level, on unpaid leave, with a nationality other than Spanish, with lower income and primiparous[547].

Some research has looked at issues of obstetric racism[548],[549] and other intersectionalities[550]. However, these are in their early stages and the scientific production, as well as their possible real reversals in institutional and/or care practice, have not yet been reflected.

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546 The Plan is available at: https://scientiasalut.gencat.cat/bitstream/handle/11351/10977/pla_abordatge_violencia_obstetrica_vulneracio_drets_sexuals_reproductius_2023_2028_2023.pdf?sequence=6

547 The magnitude of the problem of obstetric violence and its associated factors: A cross-sectional study: https://www.sciencedirect.com/science/article/pii/S1871519220303590?via%3Dihub

548 Estratificación obstétrica interseccional: https://revistes.ub.edu/index.php/contextos/article/view/39422

549 Estratificación obstétrica interseccional: https://revistes.ub.edu/index.php/contextos/article/view/39422/38482

550 Interseccionalidades de género y violencias obstétricas: https://revistes.ub.edu/index.php/MUSAS/article/view/vol4.num2.3/29481

Awareness of the main federations/associations of healthcare providers (e.g. midwives, obstetricians and gynaecologists)

Associations of health professionals have positioned themselves according to the issues, as shown below:

- The Spanish Society of Gynaecology and Obstetrics points out that obstetric violence is legally criminal, morally inadequate and scientifically an unacceptable concept[551].

- When an attempt was made to incorporate obstetric violence into the modification of the State Law on sexual and reproductive health (Law 1/2023, of 28 February, which modifies Law 2/2010, of 3 March, on sexual and reproductive health and the voluntary interruption of pregnancy), the General Council of Official Medical Associations, a nationwide organization, publicly expressed its strong opposition to it[552] and rejected the concept of obstetric violence[553].

- The Official College of Doctors of Zaragoza (COMZ), the Aragonese Association of Gynaecology and Obstetrics (AGOA), and the Aragonese Society of Contraception (SAA) have expressed their firm rejection of the term "obstetric violence"[554]. The same applies to the Andalusian Council of Medical Associations[555], the Official College of Doctors of Alicante[556] or the Society of Obstetrics and Gynaecology of the Valencian Community[557].

- The Catalan Society of Obstetrics and Gynaecology and the Council of Medical Associations of Catalonia on the other hand, released a joint statement on obstetric violence[558]acknowledging that the term may cause discomfort but highlighted its international recognition and adoption by organisations such as the United Nations. In fact, the statement is even more blunt when it states: "Denying its (obstetric violence) existence erodes the trust between women and professionals that is essential for successful pregnancy and childbirth outcomes". To eradicate this violence, it is crucial to acknowledge and enhance the education and training of professionals and society through constructive and proactive debates. Both entities expressed their commitment to being an active part of this change by undertaking initiatives to disseminate information, raise awareness, and train professionals. The statement is clear in expressing that:
"*Despite the discomfort that the term obstetric violence may generate, it has been internationally recognised and adopted by the United Nations and the European Commission, among other organisations*

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551 Violencia obstétrica: Un concepto legalmente delictivo, moralmente inadecuado, científicamente inaceptable: https://us18.campaign-archive.com/?e=e52bacb293&u=fbf1db3cf76a76d43c634a0e7&id=5a73a608b8

552 The Spanish version is available at: https://www.cgcom.es/notas-de-prensa/el-cgcom-rechaza-y-considera-muy-desafortunado-el-concepto-de-violencia-obstetrica

553 El CGCOM rechaza el concepto de "violencia obstétrica" para describir las prácticas profesionales de asistencia al embarazo, parto y posparto en España: https://www.cgcom.es/noticias/el-cgcom-rechaza-el-concepto-de-violencia-obstetrica-para-describir-las-practicas

554 https://www.heraldo.es/noticias/aragon/2023/11/27/colegio-medicos-zaragoza-rechaza-termino-violencia-obstetrica-pancartas-materno-infantil-1693949.html

555 El Consejo Andaluz de Colegios de Médicos sobre violencia obstétrica: https://cacm.es/2021/09/23/el-consejo-andaluz-de-colegios-de-medicos-sobre-violencia-obstetrica/

556 Comunicado del COMA sobre la tipificación de 'violencia obstétrica': https://coma.es/comunicado-del-coma-sobre-la-tipificacion-de-violencia-obstetrica/

557 https://www.sogcv.com/archivos/Comunicado_SOGCV_Violencia_Obstetrica_24Nov2021.pdf

558 Comunicat conjunt de la Societat Catalana d'Obstetrícia i Ginecologia (SCOG) i el Consell de Col·legis de Metges de Catalunya (CCMC) sobre la 'violència obstètrica': https://www.comb.cat/Upload/Documents/9/3/9315.PDF. The Spanish version is available at: https://www.comb.cat/upload/Documents/9/3/9316.PDF

and institutions. The Generalitat of Catalonia itself has regulated it and defined its meaning in Law 17/2020, of 22 December, amending Law 5/2008, on the right of women to eradicate male violence. It is therefore important to overcome the initial rejection of the term in order to grasp its real meaning and to be able to enter into the debate on the fundamental issues"[559]
However, the statement also points out:

"*The SCOG (*The Catalan Society of Obstetrics and Gynaecology*) and the CCMC (*the Council of Medical Associations of Catalonia*) are concerned about the possibility that the legal assimilation of obstetric violence with gender-based violence could imply the criminalisation of professionals under rules foreseen for intentional situations that are not specific to professional performance*"[560].

In December 2023, they have once again issued a statement showing their acceptance of the Plan proposed by the Health Department of Catalunya[561] for the development of a more respectful care.

Most midwifery groups and associations recognise the existence of obstetric violence in Spain and accept the term "obstetric violence"[562]. In 2021, the Catalan Association of Midwives published a position on obstetric violence[563]. The Catalan Association of Midwives stated that denying this type of gender-based violence distances professionals from reality. It is necessary for associations to work together to improve care for the sexual and reproductive processes of the population. They should also support actions that review the quality of the services offered.

Policies developed to help healthcare professionals understand and prevent this issue

The Catalan Society of Obstetrics and Gynaecology (*Societat Catalana d'Obstetrícia i Ginecologia*) launched in February 2022 the Working Group for the Study and Prevention of Obstetric Violence (GTepVO)[564]. In addition, the Germans Trias i Pujol Hospital (Badalona) has been a pioneer in promoting the constitution of a multidisciplinary Commission for the "Prevention of Obstetric Violence"[565], and Vall d'Hebron Hospital (Barcelona) also has a Zero Obstetric Violence Subcommittee.

The Universitat Jaume I (Valencian Community) has organised congresses, workshops and seminars on obstetric violence since 2019. The Society of Obstetrics and Gynaecology of the Valencian Community

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559 Original text: "A pesar de la incomodidad que el término violencia obstétrica pueda generar, ha sido reconocido internacionalmente y adoptado por las Naciones Unidas y por la Comisión Europea, entre otras organizaciones e instituciones. La propia Generalitat de Cataluña la ha regulado y ha definido su significado en la Ley 17/2020, del 22 de diciembre, de modificación de la Ley 5/2008, del derecho de las mujeres a erradicar la violencia machista. Conviene, pues, superar el rechazo que el término provoca de inicio para captar su significado real y ser capaces de entrar en el debate de las cuestiones de fondo"

560 Original text: "La SCOG y el CCMC vemos con preocupación la posibilidad de que la asimilación jurídica de la violencia obstétrica con la de violencia de género pueda implicar la criminalización de profesionales bajo normas previstas para situaciones dolosas que no son específicas de la actuación profesional."

561 COMUNICAT DE LA SOCIETAT CATALANA D'OBSTETRÍCIA I GINECOLOGIA ARRAN DE LES INFORMACIONS DIFOSES AL VOLTANT DE LA PRESENTACIÓ DEL PLA PER A L'ABORDATGE DE LA VIOLÈNCIA OBSTÈTRICA I LA VULNERACIÓ DELS DRETS SEXUALS I REPRODUCTIUS: https://docs.academia.cat/noticies/3945/1/comunicat-de-la-societat-catalana.pdf

562 See for instance: MANIFIESTO FAME CONTRA LA VIOLENCIA OBSTÉTRICA EN ESPAÑA. Por FAME: https://matronasextremadura.org/manifiesto-fame-contra-la-violencia-obstetrica-en-espana/

563 Available at: https://www.llevadores.cat/activitats/activitats-acl/gestions-col-laboracions-acl/1752-posicionament-de-l-acl-en-resposta-al-comunicat-emes-per-l-organitzacio-medica-col-legial-d-espanya

564 https://webs.academia.cat/societats/ginecol/?p=page/html/grupstreball/violencia-obstetrica

565 https://hospitalgermanstrias.cat/servei-ginecologia-obstetricia

put pressure on the Rector of the aforementioned university requesting the withdrawal of its endorsement and the suspension of the activities organised[566]. Also, at the XVII SOGCV Congress 23/24, a paper entitled "Obstetric violence: what are we talking about?" [567] was proposed, in which a profound rejection of the term and its use was shown.

On the other hand, in 2021, the Germans Trias i Pujol Hospital organised a conference on obstetric violence in collaboration with different entities[568].

To complement desk research, information (interviews via emails) was gathered from the following persons: Mònica Àlvaro Cerezo, Member of the Valencian Parliament for Compromís and Tània Verge Mestre, Catalonia's Minister for Equality and Feminism

A2.3 Croatia

Section I. Legal classification and access to justice

1.1. Legal classification of obstetric and gynaecological violence and type of penalties

In Croatia, there is no law that recognises obstetric and gynaecological violence, nor is there any work being done to create one. In addition, laws on gender-based violence do not include obstetric and/or gynaecological violence.

Women who have been victims of obstetric and gynaecological violence can (in theory) use the Protection of Patient Rights Act (*Zakon o zaštiti prava pacijenata*), at least to the extent that it refers to consent and respectful care, but there has been no knowledge of this Act ever successfully being used to bring a complaint.

1.2. Administrative and/or criminal penalties foreseen in cases of obstetric and gynaecological violence

There are no administrative or criminal penalties in cases of obstetric and gynaecological violence, however, in theory, women can bring complaints to the Croatian Medical Chamber or the Croatian Chamber of Midwives. Nevertheless, there have been no complaints that have resulted in reviews or licensing issues for health providers. If a complaint were to be successful it would likely go to a professional review/conduct board. However, if there was not grave misconduct (e.g. there was no fatality or disability as a result) and without concrete evidence (e.g. disrespectful care noted in patient record) it is unlikely that anything would happen.

One additional problem in Croatia is a lack of professional guidelines for different procedures and work, which means there is nothing that health professionals can be held accountable to implementing/using. There is also no meaningful consent process, other than signing a blank consent form at admission to hospital with no further consent discussions in the majority of cases.

A recent analysis of professional guidelines for care for reproductive health services[569], which although not specifically dealing with violence against women, still shows how problematic reproductive health

[566] https://www.sogcv.com/archivos/Carta_Rectora_UJI_Violencia_Obstetrica.pdf

[567] Programa del XVII Congreso SOGCV 23/24: https://www.sogcv.com/sogcv2023/programa.html

[568] Programa de las II Jornadas de Salud Mental Perinatal: https://www.sociedadmarce.org/IMAGES_35/violenciaobstetrica.pdf

[569] Qualitative research of guidelines for the care of mothers during physiological childbirth. | STORK (roda.hr)

is overall; the lack of guidelines creates a space where health workers do not have clear rules or pathways to adhere to and where violence can as a result be more easily hidden.

Some women have successfully made complaints to quality assurance departments in hospitals which have in rare cases resulted in letters of apology for poor treatment, although with no specific admitting of wrongdoing on the part of hospital staff.

1.3. Access to justice

In theory, women can bring complaints to the Croatian Medical Chamber or the Croatian Chamber of Midwives, however, there have been no complaints that have resulted in reviews or licensing issues for health providers.

Associations like *Roda* – Parents in Action[570] have collected data on obstetric and gynaecological violence and have denounced it publicly through fairly successful campaigns. The number of women reporting goes up (only) when there is a campaign, likely because of the stigma women feel with reporting. The only data available for this are the public social media campaigns. The reporting tools used are designed and run by volunteers[571]. The Ministry of Health does not publish statistics on the number of complaints they receive or their subject matter.

There is no data publicly available from a consistent source who collects information on obstetric and gynaecological violence, although data from the #BreakTheSilence (#PrekinimoŠutnju) campaign was analysed in a report[572].

A report on court practices and the protection of women's reproductive rights more broadly[573] showed that women face barriers such as social stigma. They are aware that there will likely be a lack of redress, because of long and expensive legal processes. A lack of health workers, especially in obstetrics and midwifery, is another reason why women often feel that they "received the best care they could under the circumstances".

Section II. Awareness and prevention

1.4. Awareness

Awareness of the issue

Awareness raising work began when *Roda* was founded in 2002, with a petition and demonstration about respectful care in maternity services called My Body – My Birth – My Choice[574]. The initial work was done as a response to harmful routine practices that were being used in Croatian maternity services, including banning or restricting companionship at childbirth, high percentages of episiotomy, Kristeller manoeuvre, harmful and violent practices (slapping women, using abusive language, threats and insults), lack of consent and more. The watershed moment was when the broader movement to end gender-based violence and feminist circles realised that obstetric violence was not medically necessary, but was yet another form of institutionalised gender-based violence.

570 www.roda.hr

571 Report | Maternity hospitals (roda.hr)

572 Qualitative analysis of patient testimonies about gynecological violence #PrekinimoŠutnju | STORK (roda.hr)

573 The first review of the case law and mechanisms for the protection of reproductive rights of women in the Republic of Croatia was made | STORK (roda.hr)

574 https://www.roda.hr/udruga/programi/trudnoca-i-porod/peticija-moj-porod-moje-tijelo-moj-izbor.html

Trainings, symposia and networking happened, and as the field and discourse developed, a round table on violence in childbirth that took place at the Croatian Parliament in 2012[575]. With the advancement of social media and increased number of people using the internet, the work quickly grew and public awareness increased. In 2015, In 2015 Roda held the Human Rights in Childbirth in Eastern Europe Conference[576] and published the conference papers also (in English)[577]. In 2014, the #PrekinimoŠutnju (#BreakTheSilence) campaign started. The Croatian translation, *porodničarsko nasilje* was used, which translates to 'obstetric violence'; however, since this term was not well understood by the general public or health workers, and because it implies that only obstetricians are perpetrators (and not midwives), a more descriptive explanation was used, namely 'violence against women in pregnancy and childbirth'[578].

Roda began a campaign on Facebook for the 16 Days of Activism, where they invited women to write their experiences, photograph and send these back to them on social media. The campaign grew and women began sharing their experiences in the comments sections on Roda's Facebook page but also in the media. The idea came from a Bulgarian organisation that had done similar work a few years earlier, which Roda was connected to through a shared EU-wide network.

Initially, the campaign was run by Roda. Over time, a small consortium of NGOs in the women's rights and reproductive rights space joined and helped amplify it. In later iterations (2018-9, 2021-2 with the Mirela Čavajda case, the coalitions were formed more easily and earlier in the campaign[579]. The case involved the initial refusal of abortion by multiple hospitals under conscientious objection even though the foetus had a brain tumour that would have either led to death in the womb or severe diseases; despite the pregnancy conditions being in line with the Croatian legal provisions on abortion, the abortion was only allowed weeks later and the case received notable social attention[580].

In October 2018 during a parliamentary session, Member of Parliament Ivana Ninčević Lesandrić told her story of obstetric violence, being tied to a table and denied anaesthetic for a surgical miscarriage procedure, for which she was told not to speak of intimate things in the parliament and accused of lying. Roda then took the opportunity to ask women to submit their experiences of painful procedures done without anaesthetic, as a form of obstetric violence[581]. These were then delivered to the Minister of Health[582]. A Platform for Women's Reproductive Health was formed, that included other women's CSOs in Croatia[583].

Their demand was the preparation of an Action Plan for Women's Health 2019-2021[584] by the Prime Minister, with a multi-stakeholder working group, clear goals and funding allotments; however, this never happened. Instead, Roda and other CSOs went ahead and prepared an Action Plan and forwarded it to the government, with no response[585].

Although there were no mid- or long-term actions, the discourse on violence against women nevertheless did become more mainstream, and public opinion clearly agreed that violence against women during pregnancy and childbirth is unacceptable and must be solved by the State –. #PrekinmoŠutnju (#BreakTheSilence) clearly contributed thereto.

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575 https://www.youtube.com/watch?v=iUOkaumG-04

576 https://www.facebook.com/media/set/?set=a.10152734561857051&type=3

577 https://www.roda.hr/en/reports/human-rights-in-childbirth-eastern-europe-conference-papers.html

578 Letter to Minister Varga on the occasion of the action Let's break the silence | STORK (roda.hr)

579 Support for accessible, safe and legal termination of pregnancy in Croatia | RODA

580 (https://www.humanrightspulse.com/mastercontentblog/mass-conscientious-objection-is-making-abortion-inaccessible-in-croatia).

581 Does our "male" society acknowledge the pain of a woman? | STORK (roda.hr)

582 Letter to the Ministry of Health regarding the action Let's break the silence 2018 | STORK (roda.hr)

583 Report from the action of reading women's testimonies | STORK (roda.hr)

584 Roda sends letter to Prime Minister about Let's Break Silence movement | STORK

585 Akcijski_plan_za_reproduktivno_zdravlje__zena.pdf (roda.hr)

After the 2014-15 campaign, once some changes were implemented elections were held and a tumultuous government change (two governments were formed over a year before a stable coalition came into power) and as a result, public pressure waned and there was no political will among the new government to continue this work.

Following the 2018-2019 campaign, the pandemic overshadowed all non-COVID 19 related health discussions, leading to a neglect of certain critical issues and the stagnation of any progress made towards the adoption of evidence-based practices within maternity services.

Resistance of professionals

Obstetricians and gynaecologists were the main opponents of these campaigns and used their position of power (exacerbated by their pressure as a profession with a shortage of practitioners and threats that doctors will move to other countries if requirements are imposed on them from the Ministry of Health) but also from powerful conservative groups who see all improvements to women's rights – even during wanted pregnancy and childbirth – as a threat. The terminology used by the main federations/associations of healthcare providers to describe obstetric and gynaecological violence is usually "miscommunication" or "misunderstanding".

How public institutions have addressed the issue?

The government made a number of promises after the first wave of the #BreakTheSilence (#*PrekinimoŠutnju*) campaign in 2014 and later in 2018[586]. However, the majority of these promises have not come to fruition[587].

After the first wave of #BreakTheSilence (#PrekinimoŠutnju) in 2014, part of the government response was to run a pilot programme of the Mother Friendly Hospital Initiative[588]. The ten steps were adapted to Croatian hospitals[589] in collaboration with civil society (e.g. removing stipulations about HIV, which is not an issue in Croatia), and a baseline assessment was done, followed by a training and assessment six months later.

However, despite calls from civil society (in 2015[590] and again in 2019[591]) no further trainings were conducted due to a government change and lack of political will. The results from the baseline assessment and post-training assessment were never made publicly available.

Roda is currently running a CERV project which has a training for health providers planned as part of the activities in the next 24 months[592].

The initial training held in 2017 was based on human rights mechanisms as they relate to women's health and care in sexual, reproductive and maternity services, prepared for a health service provider perspective. The training was held as one of many based on the ten steps for Mother-Friendly Hospitals (MFH), with each step having a 90-minute session attached to it. The training had two parts: the first was based on human rights as they pertain to reproductive health services (Step 3) services, which was

586 Chronology of action #PrekinimoŠutnju | STORK (roda.hr)
587 A year after #PrekinimoŠutnju - and the Government remains silent | STORK (roda.hr)
588 Pilot program maternity hospitalfriends of mothers and children in Croatia | Maternity hospitals (roda.hr)
589 10 Steps for Maternity Hospitals friends of mothers and children | Maternity hospitals (roda.hr)
590 A year after the action Let's break the silence | STORK (roda.hr)
591 A year after #PrekinimoŠutnju - and the Government remains silent | STORK (roda.hr)
592 RESPECT | RODA

also part of the training manual for the programme (which was never made public), but the content was similar to the Midwifery and Human Rights: A practitioner's guide by BirthRights and the British Institute of Human Rights.

The event was held at the Ministry of Health, planned as a train-the-trainers event, with representatives from the four hospitals piloting the MFH Initiative who were then supposed to run the training at their own hospitals. The team of representatives from each hospital included two of each: obstetrician-gynaecologists, midwives, neonatologists and neonatal nurses, as well as two members of ward / department management.

No further programmes have been developed, although there are some planned in the CERV project mentioned above. There are two free online courses available for women that health workers could potentially take as well, although there is no data available on their uptake: Your Rights in Pregnancy and Childbirth[593] and Empowered in the health system[594].

Women's groups are very aware of the issue, and it has been included in a number of shadow reports, for example, the shadow report on the implementation of the Istanbul Convention in Croatia[595].

No solutions are being put forth and no specific terminology is being used by institutions.

Other civil society organisations working on the issue include:

- SOS Rijeka[596] focuses on raising awareness and support
- PaRiTer[597] focuses on raising awareness
- Hrabre sestre[598] works to gain support for women seeking abortion services
- Zaklada Solidarna[599] works to raise awareness

A2.4 Poland

Section I. Legal classification and access to justice

1.1. Legal classification of obstetric and gynaecological violence and type of penalties

The concept of obstetric and gynaecological violence is not popular in the Polish criminological literature and criminal law. The concept is not mentioned in any Polish legal act, nor has it been singled out as a separate phenomenon in legal documents. It only appears in the media space and reports of non-governmental organisations. Although there are no specific legal provisions on obstetric and gynaecological violence in Poland, some manifestations of this form of violence are recognised under civil, administrative and criminal law, e.g. forced sterilisation, and are criminalised.

The Act on Patients' Rights and the Patients' Ombudsman (2008) obliges medical facilities and personnel to provide respectful medical services. It can be referred to in the case of obstetric or gynaecological violence, but this act does not mention this type of violence as such. The standard of

593 Your rights in pregnancy and childbirth | Gender Education (roda.hr)
594 Empowered in the health care system | Gender Education (roda.hr)
595 Shadow Report on the Implementation of the Istanbul Convention in Croatia | STORK (roda.hr)
596 https://www.sos-rijeka.org/
597 https://pariter.hr/eng/
598 https://hrabra.com/
599 https://solidarna.hr/?lang=en

perinatal care[600], which has been in force in Poland since January 2019, is normative and part of the Polish legal order[601]. The authorised provision is the Regulation of the Minister of Health of 16 August 2018 on the organisational standard of perinatal care.

The standard of perinatal care primarily sets out guidelines for the organisation of care that should be provided to a woman in the hospital during pregnancy, physiological labour, the postpartum period and during her care of the newborn. The standard obliges medical personnel to respect the right to informed participation in decisions related to pregnancy, labour, puerperium and the care of the newborn, including the scope of actions taken and medical procedures used; to treat the woman with respect, respect the privacy of the parturient and her sense of intimacy, and to always obtain the consent of the parturient or her legal representative for the performance of procedures and examinations.

Despite the normative nature of the organisational standard for perinatal care, many of its provisions are still far from being fully implemented. Unfortunately, there is no provision for penalties to be imposed on a hospital that does not follow the guidelines from the standard. There are also no concrete ways of enforcing this regulation in practice. The standard of perinatal care does not explicitly provide for any sanction due to the lack of implementation of the standard. Penalties can be imposed by the Patient Ombudsman in the case of a collective violation of the patient's rights against a hospital, against a medical person by a civil court, by a criminal court, or by professional bodies.

The standards, first introduced in 2012, were slowly implemented and after some times were positively perceived, not only by women themselves, but also by the staff of maternity hospitals. Unfortunately, after five years, the Supreme Medical Council did not want to agree on the regulations of the Minister of Health regarding the standard of medical procedure, considering that such standards should only be created and announced by medical experts within the guidelines of professional scientific societies. In line with this expectation, the Minister introduced an amendment to *the Act on Medical Activities,* which meant that the standard of conduct adopted in 2012 was no longer valid. It caused an incredible social response, with the key role of the Childbirth with Dignity Foundation and Ombudsmen, the national consultant for obstetrics and gynecology, doctors and midwives themselves, and, of course, women.

This social movement somehow "forced" the Minister to appoint a new team to develop a "new organizational standard for health care". The new team described below retained most of the provisions of the original standard and even introduced a few beneficial changes (e.g. the standard applied to every woman, not only during pregnancy and physiological birth; elimination of the obligation to hospitalize after the 41st week of pregnancy, introduction of the obligation to assess the risk of worsening symptoms of postpartum depression, or consent to eat and drink during labour with the doctor's consent). The team consisted of:

• Chairwoman – representative of the Ministry of Health;

• Experts - national consultants in the field of neonatology, perinatology, gynecology and obstetrics, anesthesiology and intensive care, gynecological and obstetric nursing, presidents of scientific societies, representatives of the patient's rights ombudsman, representatives of the Supreme Medical Council, the Supreme Council of Nurses and Midwives;

• Representatives of the social environment - NGOs working for perinatal and lactation care; and

• Ministry representatives.

Public consultations were held on the Minister of Health's draft regulation on the organizational standard of perinatal care. As many as 69 organizations, institutions, facilities and citizens submitted comments on it. At meetings, the Childbirth with Dignity Foundation presented the results of the

[600] https://epozytywnaopinia.pl/en/organizational-standard-of-perinatal-care

[601] The Organizational Standard of Perinatal Care in Poland, Available at: https://rodzicpoludzku.pl/uncategorized/the-organizational-standard-of-perinatal-care-in-poland/

report based on "women's voices". The standard is largely consistent with WHO guidelines. In 2012, when the standard was implemented, there was a lot of resistance due to lack of knowledge and skills (e.g., on the possibility to give birth in a vertical position). However, after a few years, also thanks to women's stronger awareness with regards to their right to expect proper care, it was largely accepted. While there were many facilities that did not meet all the requirements with regards to quality of care set by the standard, reports over the years by Childbirth with Dignity Foundation showed improved quality of care. Thus, the restoration of the standard in 2018 was no longer met with resistance but was even positively received.

The standard of perinatal care also refers to the care of the woman in special situations. However, special situations only include: diagnosis during pregnancy of a serious illness or defect in the child, miscarriage, stillbirth. Issues concerning the care of particularly vulnerable women, which can lead to discrimination and increase the risk of inequalities in access to quality maternity care, are unfortunately not addressed in the standard.

Despite demands made by both the Supreme Audit Office and the Childbirth with Dignity Foundation to introduce permanent monitoring and inspection of facilities to ensure compliance with the standard, no effect was achieved on the part of the Ministry. And despite receiving this information, the Government did not invite discussion in this regard.

The inadequacies in the implementation of the standard are currently being addressed at several levels. At the organisational level, for instance, although the standard guarantees a woman's adequate access to labour pain relief, many hospitals do not have anesthetists available to provide epidural during childbirth. Moreover, although women have the right to choose their care provider, in reality they cannot exercise this right due to staff shortage. Among barriers at individual level, working with a woman in labour requires commitment and empathy as actively supporting a woman in labour is also a physical effort. Therefore, burned-out, poorly paid staff are not always able to provide the highest level of quality care. Above all, the lack of control, the lack of data collection at national level, the lack of indicators to assess quality of care (including respectful care), the lack of monitoring and lessons learned lead to poor improvements in the provision of quality care.

1.2 Administrative and criminal penalties in obstetric and gynaecological violence cases

There are no specific provisions for administrative/punitive sanctions resulting from obstetric and gynaecological violence. Violations can be reported as:

- malpractice of the doctor and midwife (penalties depend on the recognition of the harmfulness of the act under the Penal Code)

- violation of the patient's rights (e.g. performance of an operation without obtaining consent for the procedure, lack of actual possibility of administering epidural when it is legally guaranteed, may indicate a violation of the patient's rights to respect of dignity and intimacy and treatment of pain and the right to health services). In the case of an alleged violation of a patient's rights, the court may award the injured party an appropriate sum as monetary compensation for the harm suffered based on Article 448 of the Civil Code.

However, there are no known cases of court rulings based on a finding of "obstetric or gynaecological violence".

The standard of perinatal care can also be considered a legal instrument setting patients' right, therefore, a violation of the standard can be claimed as a violation of patients' rights. Failure to comply with it constitutes a violation of the right to health services (the right to health services consistent with the current state of medical knowledge, provided with due diligence and in accordance with the principles of professional ethics).

In Poland, the *Act on the Ombudsman* was adopted by the Sejm on July 15, 1987. Pursuant to this document, ***the Ombudsman***[602] protects the freedoms and rights of people and citizens specified in the Constitution of the Republic of Poland and in other normative acts, including guarding the implementation of the principle of equal treatment. Therefore, reporting to the Ombudsman is only possible for ill-treatment in a medical facility or for actions of persons responsible for providing health services leading to a restriction of the right to health protection.

In matters concerning the protection of human and citizen freedoms and rights, the Ombudsman examines whether, as a result of the actions or omissions of bodies, organizations and institutions obliged to observe and implement these freedoms and rights, there has been a violation of the law, as well as the principles of coexistence and social justice. It is possible to report a case of discrimination by a medical entity to the Commissioner. The Commissioner examines whether, as a result of the action or omission of bodies, organizations and institutions obliged to respect and implement these freedoms and rights, there has been no violation of the law. After reviewing each application submitted to him, the Ombudsman may:

1) take up the case,

2) stop short of indicating to the applicant the remedies available to him or her

3) refer the matter to the competent authority

4) not take up the case, notifying the applicant and the person concerned thereof.

Health care services provided without due diligence, lack of information from the doctor about the state of health and treatment, problems with obtaining copies of medical records, violations of the standard of perinatal care - these are all factors that constitute grounds for complaints to the Patient Ombudsman. The Ombudsman performs its tasks with the help of the Office of the Patient Ombudsman.

Rights and penalties are found in the Law on Patients' Rights and the Patients' Ombudsman. When the Ombudsman issues a decision declaring a practice to be in breach of patients' collective rights, they order the practice to be discontinued or indicates the actions necessary to remedy the effects of the breach of patients' collective rights, setting deadlines for taking such actions. The decision is given the order of immediate enforceability.

The Patient Ombudsman may impose on the entity providing health services a fine of up to PLN 500,000 in the event of a breach of patients' collective rights. The minister in charge of health shall be a higher-level authority in the cases of imposing a fine. In the case of professional medical practices, the resolution on imposing a financial penalty is taken by the competent district medical council.

Potential cases of obstetric and gynaecological violence would be classified according to the act - e.g. verbal violence is a violation of human rights in terms of the right to be treated with dignity. In the case of obstetric violence related to neglect - this is a violation of the right to services (patient rights). It is possible to ask the Patient Ombudsman to access the cases and analyse whether there are records of obstetric violence.

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[602] The manner of recruitment to the position of Patient Ombudsman and its competences is regulated by the Act on Patient Rights and Patient Ombudsman. The Ombudsman for Patients' Rights is appointed by the Prime Minister from among persons selected through an open and competitive recruitment process. Pursuant to Article 43. 1. of the aforementioned Act, the Ombudsman may be a person who fulfils the following criteria jointly:

1) he/she has at least a university degree and a master's degree or other equivalent;

2) he/she has not been validly convicted of an intentional crime;

3) her health condition allows her to properly perform the function of the Ombudsman;

(4) he or she has the knowledge and experience that give him or her good grounds for the proper performance of the Ombudsman's duties.

1.3. Access to justice

There is no specific procedure in the event of a violation of the standard, but a complaint can be filed with several authorities, most of which have internal complaint procedures. A woman can write a complaint to:

1. The Hospital Management:

   However, hospitals do not provide an independent commission, they may only send the complaint for consideration to further instances e.g. the Ombudsman for Patients' Rights which rather rarely happens. Some hospitals, out of concern for patients and their good image, are increasingly employing patient rights commissioners, who are supposed to uphold the compliance of these rights by the institutions. As they are hospital employees, in practice their role is often limited to an advisory function and the mitigation of conflicts at the interface between patient and medical staff. The Commissioner, upon receipt of a complaint from a patient, 'undertakes an investigation of the circumstances surrounding the complaint to determine whether patient rights have been violated' and informs the Medical Director of the case.

2. The Patient Ombudsman
3. The Supreme Medical Council, if the doctor is at fault
4. The Supreme Council of Nurses and Midwives, if the fault lies with the midwife or nurse
5. National Health Fund if:

   a) woman was refused an appointment with a doctor

   b) woman was refused care

   c) woman was ordered to pay for a service that should have been provided under insurance (free of charge for the patient)

   d) patient had difficulties making an appointment with a doctor, e.g. appointments are only possible in person or on designated days

   e) the doctor does not see patients during the hours he/she should

   f) patient received a prescription without the reimbursement to which she is entitled.

Importantly, the *Code of Administrative Procedure* (Journal of Laws 2023.775) guarantees women the right to submit complaints and applications to state authorities, local government bodies, organisational units and social organisations and institutions. This means that the state hospital must respond to the complaint, but the private hospital is no longer obliged to respond to the complaint.

The number of reported violations of patient rights under ongoing investigations by the Ombudsman for explanatory proceedings was 114 in 2019, 204 in 2020, and 201 in 2021[603]. Some of the violations may have concerned, for example, the terms of service. It can only be presumed that some of these reports relate to violence.

The number of complaints generated in an online tool create by Childbirth with Dignity Foundation to help women write complaints in 2023 was 1097, these are complaints that women would have sent directly to hospitals - following an intensive campaign on violence against women. The Foundation received 121 complaints. 600 women benefited from legal advice, the majority relating to obstetric violence. In 2022, 324 women used the generator. This shows how important it is to campaign to make women aware of their right to complain.

[603] (Explanatory proceedings conducted by Patient Ombudsman in individual matters in 2019-2021).

The increase in the number of statements regarding violations of patient rights in the Department of Gynaecology and Obstetrics was related to, among others, the organisation of perinatal care in epidemic conditions, particularly an unjustified and complete ban on family deliveries or their significant limitation. Consent to participate in a family birth was often conditional on meeting additional requirements of the hospital director, e.g. presenting a COVID-19 test result before labour, which is no older than five days. This meant that the family was exposed to additional costs of a privately performed test, as well as the time requirement for the validity of the test result being unrealistic to meet due to the often unpredictable date of labour. The conducted explanatory proceedings also concerned the finding of a violation of the patient's rights to provide health services contrary to current medical knowledge by, for example, preventive separation of the mother from the child immediately after labour (without taking into account medical reasons and standards of perinatal care).

Section II. Awareness and prevention

1.2. Awareness

Recently, some actions have been taken to improve the situation. In 2019, the Parliamentary Women's Rights Team was established, which organises regular meetings with the Ombudsman[604] with the objectives to:

1. guarantee women the full realisation of the constitutional principle of equality.

2. undertake educational and legislative initiatives for the equal status of women and men.

3. promote gender equality in the public, professional space, in line with the principles in force in the European Union.

Within the framework of the Team's mandate, working groups have been established to prepare initiatives to counter violence against women, counter discrimination against women at universities and in education, promote equality of women in sport, counteract prohibitions on getting pregnant and having children, and on maternity care.

A total of 20 meetings were held until 23 August 2023, in which decisions were made on:

1) Police intervention in Krakow hospitals against a patient, Ms Joanna, who had taken the abortion pill. They made a declaration for a law decriminalising abortion.

2) The ruling of the irregularly composed Constitutional Tribunal[605] of 22 October 2020 on the unconstitutionality of the provisions of the Act of 7 January 1993 on family planning, protection of the human foetus and the conditions of permissibility of abortion. The opinion of the irregularly composed Constitutional court eliminated the premise of permissibility of legal abortion due to a high probability of severe and irreversible impairment of the foetus or an incurable disease threatening its life. This opinion introduced an almost total ban on abortion in Poland, a ban which deprives women of their fundamental rights, their autonomy, their ability to determine their own lives. It deprives freedom and civil rights. Being forced to give birth against one's will exposes women to unimaginable suffering, especially when the child born dies after birth - this is considered a form of torture by UN and EU human rights institutions. Members of the Team have supported, participated in and provided support to protests related to the tightening of abortion laws in Poland.

[604] https://www.sejm.gov.pl/sejm9.nsf/agent.xsp?symbol=ZESPOL&Zesp=593

[605] See ECHR Decision (May 2021), Xero Flow w Polsce sp. Z o.o. v. Poland, available at: https://hudoc.echr.coe.int/app/conversion/pdf/

3) Calls for respect for women's rights and freedoms. The Parliamentary Group for Women's Rights strives to ensure that Polish women regain the right to decide on their lives, including abortion, as soon as possible, to regain their subjectivity, autonomy and dignity.

4) Calls on the authorities to restore the right of citizens to demonstrate peacefully without harassment, violence and repression.

5) Amendments to the law on violence against women, including domestic, sexual, economic violence. The demand "No tolerance for violence against women" was tabled in the parliament.

In 2020, the Parliamentary Team for Perinatal Care[606] was established with the following objectives:

1. to evaluate the actual state of the applied methods of perinatal care in Poland.

2. to analyse legal regulations applied in other countries.

3. to exchange of information with experts and patients.

4. to formulate propositions for further changes in national legislation.

Within the framework of the conducted activities, cases concerned:

- The process of separating a newborn from a healthy mother shortly after birth during the SARS-CoV-2 virus emergency. Separation of babies from their mothers was most often done for two reasons. The first was the time spent waiting for the mother to test negative for coronavirus (despite the absence of symptoms). During this period, women were placed in isolation rooms. Depending on the region of Poland, this procedure took two to three days. The woman was thus deprived of contact with her child during the entire hospital stay. Another issue was prolonged stays of the newborn in hospital due to prolonged jaundice or other adaptation disorders, in which the mother could not participate, as she was discharged from the hospital and had to leave the institution, leaving her newborn child behind.

- The prohibition of family births during the spread of the SARS-CoV-2 virus

- The obligation for parturients to cover their mouths and noses. Covering the mouth and nose in a highly stressful and physically demanding situation and can be harmful to women giving birth and their babies.

Organisations working on the issue of obstetric and gynaecological violence

Women can apply for psychological help and legal support in the event of being victims of obstetric and gynaecological violence to:

- Centre for Women's Rights[607]
- Childbirth with Dignity Foundation[608], which offers:
  - advocacy for women,
  - awareness raising for women about their rights - educational webinars, legal support, social campaigns engaging women to write complaints using a developed IT tool
  - training and conference for staff in respectful maternity care
  - guard interventions in the event of violations of women's rights in hospitals
  - legal support for victims of obstetric and gynaecological violence
- FEDERA Foundation for Women and Family Planning[609]
- Matecznik Foundation[610], which provides:
  - webinars on women's rights

[606] https://www.sejm.gov.pl/sejm9.nsf/agent.xsp?symbol=ZESPOL&Zesp=728

[607] Centre for Women's Rights: https://cpk.org.pl/

[608] Childbirth with Dignity Foundation: https://rodzicpoludzku.pl/interweniujemy/strazniczki/

[609] FEDERA Foundation for Women and Family Planning: https://federa.org.pl/

[610] Matecznik Foundation: https://fundacjamatecznik.pl/

- psychological and legal support for women

Initiatives to collect women's voices and experiences on the issue

Childbirth with Dignity Foundation has been collecting women's voices regarding their perinatal experiences since 1996. Others organisations have collected women's experiences regarding losses (Matecznik Foundation), and disabled women's experiences of gynaecological care ("Kulawa Warszawa" Foundation).

There is an Instagram page, *pathogynecologia*, where women can share stories of violations related to gynaecological care. In addition, FEDERA CREATED a guide illustrating the current state of compliance with reproductive rights in Poland[611].

Since 2019, the Childbirth with Dignity Foundation has been developing a network of local activists - *Guardians of giving birth with dignity*. 35 activists from all over Poland were trained. The Guardians increase women's participation by encouraging them to complete the "Voice of Mothers" survey after giving birth, educate women and local communities on their rights in perinatal care, and are also invited in hospitals and offices where they present perinatal care in facilities from the women's perspective. Thanks to their unique knowledge of local conditions, the Guardians can take action to push for more effective change and support facilities in the long term in improving the quality of care. Introducing lasting changes takes many years and requires constant vigilance from activists. As the pandemic has shown, the challenges faced by the healthcare system may negatively impact the realisation of women's rights when accessing healthcare. Medical staff cannot participate in the Guardian project due to the possible negative consequences of undertaking interventions (including dismissal from work)[612].

Government-led initiative to address the issue

The government has not yet taken any action to counteract obstetric and gynaecological violence. However, it is worth mentioning the report of the Supreme Audit Office of 2015[613]. The conclusions and recommendations resulting from this audit still need to be fully considered. The term violence or abuse does not appear throughout the document. However, the conclusions of the report describe such behaviour: «*The inspected maternity wards did not provide patients and newborns with the required quality of medical services. The regulations governing the requirements for premises and necessary staff, as well as the standards of perinatal care, allowed for a number of derogations, were applied to an extent inappropriate to the actual needs, and were often even not complied with. These regulations are therefore not an effective tool to ensure an appropriate level of safety for patients and newborns, as well as respect for privacy and dignity*. » « *Most of the medical entities inspected did not provide adequate delivery rooms, which resulted in a violation of the patients' right to intimate and dignified medical services, including the inability to administer epidural anaesthesia during vaginal delivery* ». « *The percentage of medical interventions during childbirth was very high, in the inspected units the scale of intervention was even higher than before the entry into force of perinatal care standards and was often several times higher than the average in other developed countries. Every third newborn was fed with modified milk* ».

Initiatives targeting specific groups of women

611 https://federa.org.pl/przemoc-instytucjonalna/

612 https://rodzicpoludzku.pl/interweniujemy/strazniczki/

613 Report Perinatal Care in Maternity Units, 2015

No detailed research has been carried out on obstetric and gynaecological violence targeting specific groups of women. However, from the statements of open women in the Childbirth with Dignity Foundation research[614], it appears that the group particularly affected are obese women, women who ask too many questions, come from a different cultural background and teenagers. In Poland, women also have problems with access to legal abortion and, in some areas, to contraception[615].

There is a foundation dealing with women with disabilities that works in the field of helping women and has created a search engine for friendly gynaecological offices[616]. The Childbirth with Dignity Foundation and the Polish Migration Formula Foundation provided perinatal support to migrant and refugee women in Poland[617].

1.3. Prevention

Healthcare providers' response to the issue

These issues are still not addressed by the medical environment. Reports presented at scientific conferences addressed to the medical community, but they talked about violating the patient's rights instead of using the term obstetric and gynaecological violence.

- 2017 – A Conference organised by Supreme Bar Council "Patients' rights - without anaesthesia."
- 2018 – A conference was organised by the Childbirth with Dignity Foundation, "How are women treated in maternity wards? - results of monitoring maternity wards."

There are also no policies or guidelines addressing the issue of obstetric and gynaecological violence. Some hospitals are subject to accreditation, which is a general accreditation relating to the quality of medical services provided by the facility that obliges practitioners to provide care at the highest level. In 2004, The Childbirth with Dignity Foundation published a guide on observing patient rights and examples of good practices for medical staff[618].

Training provided to healthcare professionals

In 2018, the Ministry of Health announced a tender for training on changes in the standard in two voivodeships (out of 16 voivodeships in Poland). Most midwives in Poland, however, had to use their own resources to get trained (e.g. on supporting delivery in vertical positions during childbirth or alleviating labor pain, or to use, for example, training conferences conducted by the Childbirth with Dignity Foundation, with finances obtained as part of grants). Sometimes the facilities funded staff training, but they were not financed by the state.

From time to time, state grants for improving the perinatal situation appear (e.g. the recent call for proposals for lactation training for midwives and handbooks for women on patient rights), but in the opinion of NGOs, these funds are not always spent on the right activities and thus do not sufficiently translate into improvements in the quality of care, including the prevention of obstetric-gynaecological violence.

The **Childbirth with Dignity Foundation** received the 2015 Sasakawa Health Prize form WHO and was the winner of United Nations Population Award.

The Foundation carries out activities in four main areas, including training for healthcare professionals:

1) **Continuous monitoring of perinatal care**, including adherence to the standard of care and human rights of women in the perinatal period - consisting of collecting surveys from women

[614] Report from monitoring of maternity units perinatal care in Poland, 2018.

[615] Violence Institutional in Poland about Systemic Violations of Reproductive Rights, 2019.

[616] https://dostepnaginekologia.pl/

[617] https://forummigracyjne.org/projekt/wsparcie-integracji-cudzoziemcow-na-mazowszu

[618] https://rodzicpoludzku.pl/publikacje/jak-przestrzegac-praw-pacjenta-przyklady-dobrych-praktyk/

and publishing a summary report, conducting research on adherence to the rights and conditions of perinatal care, collecting surveys from hospitals and creating a hospital search engine based on these (with options for women to comment on the facilities declared by the facility). The number of hits on the hospital information portal exceeds 2 million and the number of users exceeds half a million. The foundation also wrote studies and recommendations for the Ministry of Health.

2) **Interventions -** intervening when women's rights are violated, talking to policy makers, publishing reports on maternity care and speaking out about women's experiences. Empowering and encouraging women to take action towards change. Conducting actions, petitions and publicizing violations of women's rights, visiting facilities from which the most complaints and negative assessments by women originate, meeting with Ministry representatives and the Patient Ombudsman, as well as participating in any initiatives to support the quality of perinatal care. On the Foundation's website, there is a generator for writing complaints when a woman's right to a dignified birth has been violated.
3) **Education -** aimed at both women and medical staff. Celebrating the week of dignified childbirth (webinars for women, meetings, workshops), training conferences for staff (on vertical positions, human rights, communication). The Foundation runs a closed FB group for women - 26,000 participants. Maintaining a website[619] that includes a search engine of maternity hospitals with their ratings and offers, as well as a lot of educational content.
4) **Support -** Every year a Hospital Ranking is published - based on "voice of women" surveys showing the best maternity facilities rated by women (which motivates hospitals to improve quality) and a competition called *Angels of Childbirth with Dignity Foundation*, the best rated midwife by women. There is also a gratitude generator on the foundation's website - with which women can express their thanks to midwives for their work.

A2.5 Portugal

Section I. Legal classification and access to justice

1.4. Legal classification of obstetric and gynaecological violence

Law no. 15/2014, of March 21, consolidates the rights and duties of the users of the healthcare services, and contemplates the right of woman during childbirth to be accompanied by a person of her choice (articles 12-18)[620]. Law no. 15/2014 was amended by Law no. 110/2019, of September 9th, which establishes the principles, rights and duties applicable to the protection of preconception, medically assisted procreation, pregnancy, childbirth, birth and the puerperium, with a view to consolidating them, covering health services in the public, private and social sectors[621].

According to Law 15/2014, as amended by Law no. 110/2019[622], every woman has the right to:

- Right to privacy and confidentiality – Article 15.º A, no. 1, b);
- Right to continuous assistance during the postpartum period – Articles 15.º G and 18, no. 2;
- Right to decent and respectful treatment (free from coercion, violence and without discrimination, right to a humanized birth) – Article15.º A, no. 1, c), d), e);
- Right to an interpreter if necessary – Article 15.º C, no. 3;
- Right to information, refusal and informed consent – Article15.º A, no. 1, a)
- Right to freedom/autonomy and self-determination – Article 15.º A, no. 1, g);
- Right to the best healthcare – in accordance with the EBM and WHO Recommendations – Article 15.º A, no. 1, f) and Article 15.º F, nº 2 and 6;
- Right to breastfeeding – Article 15. º-H;

619 https://gdzierodzic.info/#

620 https://diariodarepublica.pt/dr/detalhe/lei/15-2014-571943

621 https://www.iasaude.pt/attachments/article/6320/lei_110_2019_procriacao_medicamente_assistida.pdf

622 https://diariodarepublica.pt/dr/detalhe/lei/110-2019-124539905

- Right to pain relief – Article 15.º F, no. 4;
- Right to minimal interference – 15.º F, no. 2 and 6;
- Other rights as a user: right to association, access to healthcare, making complaints and accountability.

A proposal of law ("Projeto de Lei n. º 912/XIV/2.ª") - to strengthens the protection of women in pregnancy and birth through the criminalization of obstetric violence was proposed in 2021, but was not adopted[623]. The 2021 draft proposed alterations to the 110/2019 law and to the penal code. Through several amendments to Article 15. º A (presented below), the draft law proposed a legal definition of obstetric violence:

"*4 - Obstetric violence is considered to be any conduct directed at women, during labor, birth or the postpartum period, carried out without their consent, which, constituting an act of physical or psychological violence, causes pain, damage or unnecessary suffering or limits their power of choice and decision.*
5 - For the purposes of the provisions of the previous paragraph, the following are understood as:
a) Physical violence, the use of force or physical restrictions, namely the performance of the Kristeller maneuver, physical attacks, restrictions on freedom of movement imposed on the parturient woman, forced fasting, the use of pharmacological means without authorization, the induction of labor, the administration of oxytocin and the intentional or negligent denial of pain relief to the woman in labor;
b) Psychological violence, the use of inappropriate, rude and threatening language to the woman's self-esteem, including situations of discriminatory treatment, disregard of the parturient woman's requests and preferences, omission of information about the course of the birth and the procedures adopted and the prohibition of the accompanying person to stay.
6 - The use of episiotomy in cases where there is no medical justification for its practice constitutes the crime of female genital mutilation, foreseen and punished under the terms of article 144 º of the Penal Code."

Amendment to the article 144 on female genital mutilation was also foreseen, stating:

"Article 144.º-A[...]1 - [...].2 - [...].3 - *Interventions carried out by a doctor or other legally authorized person that result in the genital mutilation of a female person, in violation of the leges artis and thus creating a danger to life or a danger of serious harm to the body or to health, are punished with a prison sentence of up to 2 years or a fine of up to 240 days, if a more serious penalty is not applicable to them due to another legal provision.*" According to such definition, episiotomy without clinical indication should be considered female genital mutilation.

The law proposal 912 aimed to add as well an article 166. º-A in the penal code as follows:
Obstetric Violence
1 - Anyone who subjects a woman, during labor, childbirth or the postpartum period, to physical or psychological violence, which causes her pain, damage or unnecessary suffering or limits her power of choice and decision-making , is punished with a prison sentence of up to 1 year or a fine.
2 - Criminal proceedings depend on a complaint.
3 - The penalty is increased by one third, in its minimum and maximum limits, if the crime is committed:
a) In the presence of stillbirth or termination of pregnancy;
b) Against people at the extremes of reproductive age;
c) Against mother, unborn child or child with disabilities;
d) Against victims of domestic violence, sexual abuse, harmful practices or human trafficking;
e) Against people living in extreme poverty, particularly those with income below the poverty line or low levels of literacy;
f) Against migrants and refugees."

[623] https://debates.parlamento.pt/catalogo/r3/dar/s2a/14/02/167/2021-07-14/2?pgs=2-11&org=PLC

The genesis of this draft law goes back to COVID-19 and related problems with accessing maternal and newborn healthcare, which worsened during the pandemic, and against which women complained. Consequently, some politician (such as Cristina Rodrigues) advocated for a change in legislation. Although there was also a Parliamentary resolution in 2021 on obstetric violence, the argument put forward to change the legislation was the increased number of complaints and the lack of concrete improvements.

However, the National Board of Physicians (*Ordem dos Medicos*) some political parties, and some associations opposed the draft law on the grounds that:

- The quality of the text was poor;
- Lack of evidence on the scope (and existence) of obstetric violence;
- Difficulty to criminalise obstetric violence, since some of the acts that would be criminalised are medical acts, that can sometimes be considered as violent acts but might be necessary depending on the circumstances in which they are carried out; and
- Subjectivity related to physical or psychological violence, because pregnant women can feel pain, but that is not obstetric violence, while the draft law suggested that inflicting pain could be a crime in itself.

The College of Genecology and Obstetrics from the National Board of Physicians also issued an opinion on the Proposal of Law n912/XIV/2.ª[624]:

"The term obstetric violence is inappropriate in countries where excellent maternal and child health care is provided, as is the case in Portugal. The term does not fit the reality we live in these countries; raises alarm, fear and distrust among pregnant women and their families and calls into question health professionals who strive to provide them with the best possible care, according to the best and most current scientific evidence (…)". The need for the law n912/XIV/2.ª "(…) is not supported by the reality of providing obstetric health care in Portugal and the legal definition of obstetric violence must be refuted and, consequently, the proposed concepts of physical and psychological violence"[625]

In addition, the Portuguese Bar association also issued an opinion on Proposal of Law n912/XIV/2[626], in which they considered that there is already a legal framework in place to criminalise such practices.

"*After analysing the document in question, and without commenting regarding the proposed wording of the amended and/or added articles, we highlight that health professionals are already obliged to act in accordance with the applicable legis artis. Any intervention that is not clinically necessary is likely to constitute bad practice, punishable under the terms of the provisions of art.156 of the Penal Code. It is true that many of the other behaviours included in the draft law under analysis, are also covered by the current regulatory framework. However, we believe that the relevance of the subject in question and the need for a possible legislative change, namely, to creation of a new legal type of crime, requires debate sustained by in-depth technical and scientific studies aimed at the Portuguese reality*"[627].

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624 Statement from College of Genecology and Obstetrics from the National Board of Physicians https://ordemdosmedicos.pt/wp-content/uploads/2017/09/Parecer-Projeto-Lei-912XIV-2.pdf

625 Ibid

626 Parecer da Ordem dos Advogados sobre o projeto de decreto-Lei n.º 912/XIv/2.º, que visa reforçar a proteção das mulheres na gravidez e parto através da criminalização da violência obstétrica (2021). Available at: https://portal.oa.pt/media/134344/projeto-de-decreto-lei-n%C2%BA-912-xiv-2.pdf

627 https://portal.oa.pt/media/134344/projeto-de-decreto-lei-n%C2%BA-912-xiv-2.pdf

In 2023, there were two new law proposals and one resolution proposal submitted at the same time to the parliament by the parliamentary group "Bloco de Esquerda". However, due to the fall of the government a few days later, these proposals were not discussed.

1.2. Administrative and/or criminal penalties foreseen in cases of obstetric and gynaecological violence

While there is no specific penalties foreseen for obstetric and gynaecological violence, any medical intervention that is not clinically necessary is likely to constitute malpractice, punishable under the terms of the article 156 of the Penal Code "Arbitrary medical-surgical interventions and treatments"[628]:

1 - The people indicated in article 150 of the penal Code (*Código Penal Artigo 150*) who, in view of the purposes indicated therein, carry out interventions or treatments without the patient's consent are punished with a prison sentence of up to 3 years or a fine.

2 - The act is not punishable when consent:

a) Can only be obtained with a postponement that involves danger to life or serious danger to body or health; or

b) Was given for a certain intervention or treatment, and a different one was carried out because it proved to be imposed by the state of knowledge and experience of medicine as a means to avoid a danger to life, body or health, and there were no circumstances that allowed to safely conclude that consent would be withheld. If, through gross negligence, the agent falsely represents the prerequisites for consent, he or she will be punished with a prison sentence of up to 6 months or a fine of up to 60 days.

1.3. Access to justice

Complaint mechanisms can involve many bodies, such as the Health Regulation Authority (ERS), the General Health Directorate (DGS), the General Inspection of Health Activities (IGAS), the National Board of Physicians, the Portuguese Order of Nurses, Justice Provider.

- In the public sector, the complaint should be raised in the Yellow Book available at the healthcare facility or online[629]

- In the private sector the complaint should be raised in the (Red) Complaint Book available at the healthcare facility or online[630]

- The complaint should also be made to the Health Regulation Authority[631]

The Health Regulation Authority (ERS) now has a category "obstetric violence complaints". Once the denomination has been selected by the complainant, ERS cannot change it. ERS belongs to the Ministry of Health but is an independent authority. However, when someone complains to ERS, the complaint is directed by ERS to the health provider and ERS considers the case closed as soon as the health provider responds, even if their response may be disregarding the complainant. The Association for Women's Rights in Pregnancy and Childbirth made a complaint to the ERS regarding companionship

628 https://www.pgdlisboa.pt/leis/lei_mostra_articulado.php?artigo_id=109A0156&nid=109&tabela=leis&pagina=1&ficha=1&so_miolo=&nversao=

629 https://www.livroamarelo.gov.pt/

630 https://www.livroreclamacoes.pt/Inicio/

631 https://www.ers.pt/pt/

of choice in 2021, and that led to a commission conducting an unannounced visit to the healthcare facilities for inspection. However, ERS does not conduct a lot of investigation, especially in cases of obstetric violence, because there is a common misconception that this issue is too medical and only physicians can have a say in these matters. Indeed, if the complaint is found grounded, ERS only releases a type of recommendation stating some ground rules. ERS also releases trimestral report[632].

The complaint can also be raised to the Professional Orders against a healthcare professional:

- National Board of Physicians, fill out the form and send it by current mail or by email[633].

- The Portuguese Order of Nurses, through the EuAlerto platform, to the Regional Section of the order and send it by regular mail or by email[634]. The consequences may include reprimand, suspension from exercising the profession and expulsion.

However, most women only know the "complaint book", which is often disregarded because it requires filing a complaint *in loco* when they are still suffering from mistreatment. Some hospitals have citizen's offices ("gabinetes do cidadão"), which function as mediators (and can thus limit recourse to judicial trials). There is no formal support to help people report their birth experiences.

In addition, since there is no specific criminal offence for obstetric violence, women have been encouraged to file complaints based on other crimes. As a result, women might think that what they experienced is not constituting a crime, and may therefore end up not formalising complaints.

The Portuguese Observatory for Obstetric Violence[635] has available information on their website on how to file a complaint on obstetric violence. OVO Portugal has also an anonymous place for healthcare providers denounce this violence[636]

Alternative spaces women can use to denounce this violence are:

- Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto[637]
- Associação Saúde das Mães Negras e Racializadas em Portugal (Samanepor)[638]

632 https://www.ers.pt/media/lldhcpnm/publica%C3%A7%C3%A3o-delibera%C3%A7%C3%B5es-4-%C2%BA-trimestre-de-2021.pdf

633 https://ordemdosmedicos.pt/formulario-de-reclamacao-do-doente/

634 https://srcentro.ordemenfermeiros.pt/

635 OVO Portugal, Legal Steps to React in the Case of Obstetric Violence. Available at: https://ovoportugal.pt/passos-juridicos/

636 https://ovoportugal.pt/denuncias/

637 https://associacaogravidezeparto.pt/

638 https://www.enar-eu.org/user/samane/

Section II. Awareness and prevention

1.5. Awareness

The Portuguese Association for Women' Rights in Pregnancy and Childbirth has conducted a survey on the experiences of women who gave birth in 2012-2015[639] and in 2015-2019[640].

A Resolution of the Parliament was issued in 2021 recommending the government to take measures to eliminate obstetric violence and conduct a study on this type of violence in Portugal (*Resolução da Assembleia da República n.º 181/2021, de 28 de junho*) [641]. There is also a resolution of the Parliament that was issued in 2021 too, recommending the government to eradicate female genital mutilation[642].

Some organisations provide support to women and training for women and healthcare professionals:

- **Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto** (Portuguese Association for the Rights of Women in Pregnancy and Childbirth) [643]
- ***OVO Portugal*** [644]
- **Associação Saúde das Mães Negras e Racializadas em Portugal (Samanepor) (the Association for the Health of Black and Racialized Mothers in Portugal)**[645]
- **Portuguese Association of Obstetric Nurses**[646]
- **Nascer com direitos (Born with rights)**[647] is a website developed by a Portuguese lawyer very active on the issue of birth rights. She provides training and has written a book to inform the general community on the rights during pregnancy and childbirth[648]:

  Training:

  1. Workshops and webinars for pregnant women/couples on pregnancy and childbirth issues

  2. Training for health professionals on the legal aspects of clinical practices. For midwives, she also provides specific training on the legal aspects of home births and what contracts should contain.

639 https://associacaogravidezeparto.pt/wp-content/uploads/2016/08/Experi%C3%AAncias_Parto_Portugal_2012-2015.pdf

640 https://associacaogravidezeparto.pt/wp-content/uploads/2020/12/Experie%CC%82ncias-de-Parto-em Portugal_2edicao_2015-19-1.pdf

641 https://diariodarepublica.pt/dr/detalhe/resolucao-assembleia-republica/181-2021-165865615

642 https://diariodarepublica.pt/dr/detalhe/resolucao-assembleia-republica/69-2021-158240144

643 Training: https://associacaogravidezeparto.pt/formacao/, Campaigns: https://associacaogravidezeparto.pt/campanhas-e-eventos/

644 Support: https://ovoportugal.pt/denuncias/; https://ovoportugal.pt/envia-o-teu-testemunho/; https://ovoportugal.pt/apoio-psicologico/, Campaigns: https://ovoportugal.pt/comunicados/

645 Campaigns: https://www.instagram.com/samane_portugal/

646 Training: https://apeo.pt/cursos-e-workshops/ Ethical-Relational Skills Development Course in Maternal Health and Obstetric Nursing. The training discussed legal aspects in Maternal Health and Obstetric Nursing, women's rights during labour, birth and the postpartum period (in times of pandemic) and obstetric violence.

647 https://nascercomdireitos.pt/comeca-aqui/#

648 https://nascercomdireitos.pt/e-book-os-meus-direitos-na-gravidez-e-no-parto/

She collaborates with the Portuguese Association of Obstetric Nurses[649] since 2017. She is part of the board of the Portuguese Association of Women Jurists[650]. She is invited to provide training in hospitals, invited by the medical students association, and by the nurses specialists in maternal and obstetric health.

- **UTERUS (private company)[651]**

  They have training for professionals that includes one topic (among a total of 9 topics) on the WHO guidelines for a positive experience of birth.[652]

Research carried out to address issues in relation to obstetric and gynaecological violence faced by specific groups of women

Associação Saúde das Mães Negras e Racializadas em Portugal (Samanepor) has issued a report on black and afro-descendent women, with 20% of black and Afro-descendant women in Portugal reporting to have faced obstetric violence during pregnancy. 24% of women reported having suffered obstetric violence during childbirth. Furthermore, during this period of pregnancy, a significant percentage reported feeling neglected (23.4%), disrespected (19.7%) or humiliated (17%)[653].

IMAGINE EURO has published a paper on the quality of care provided to migrant vs non-migrant women with data from several countries including Portugal. Migrant women who experienced labor perceived slightly more difficulties in attending routine antenatal visits (41.2% [n = 621] vs 39.4% [n = 7063]; P = 0.001), barriers in accessing the facility (32.9% [n = 496] vs 29.9% [n = 5358]; P = 0.001), not receiving timely care at facility arrival (14.7% [n = 221] vs 13.0% [n = 2331]; P = 0.025), inadequate room comfort and equipment (9.2% [n = 138] vs 8.5% [n = 1524]; P = 0.004), inadequate number of women per rooms (9.4% [n = 142] vs 8.6% [n = 1537]; P = 0.039), not being allowed to stay with their baby as they wished (7.8% [n = 117] vs 6.9% [n = 1235]; P = 0.011), less likely to report no early breastfeeding (10.1% [n = 152] vs 13.7% [n = 2460]; P = 0.002), and more likely to suffer physical/verbal/emotional abuse (14.5% [n = 218] vs 12.7% [n = 2280]; P = 0.022) than non-migrant women who experienced labor. Migrant women who had a prelabor cesarean were more likely not to receive pain relief after cesarean (16.8% [n = 46] vs 13.5% [n = 371]; P = 0.039) and less likely to provide informal payment (1.8% [n = 5] vs 4.4% [n = 122]; P = 0.005) compared with non-migrant women who had a prelabor cesarean[654].

1.6. Prevention

Initiatives by healthcare providers to address the issue

- Webinar. I Meeting of Maternal and Obstetric Nursing. Respect and Equity: From pregnancy to parentality. 5 March 2021. With a round table exclusively dedicated to obstetric violence[655].

649 https://apeo.pt/

650 https://www.apmj.pt/

651 https://uterus.pt/sobre-nos/missao/

652 https://uterus.pt/profissionais/programa-nascer-positivo-promocao-do-parto-fisiologico/

653 Report on black and afro-descendent women in Portugal regarding their obstetric experiences (2023). https://afrolis.pt/samane-partilha-primeiro-estudo-sobre-racismo-obstetrico-em-portugal/

654 Quality of maternal and newborn care around the time of childbirth for migrant versus nonmigrant women during the Covid 19 pandemic: Results of the iMAGINE Euro study in 11 countries of the WHO European region available at : (nih.gov) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9877819/#ijgo14472-supitem-0001

655 https://i-d.esenf.pt/encontro-saude-materna-obstetrica/?doing_wp_cron=1712735128.8565640449523925781250

- Parallel session on Obstetric Violence at the IX National Congress of the Students of Medicine. Porto, 28-30 October
- Transgressive - Controversial Themes in Sexual and Reproductive Health. Online session promoted by the National Association of the Students of Medicine. 5 November 2022.
- Violence, bioethics and patient security: A luso-brazilian discussion. Online session. 27th May, 2023.[656]
- 15th JC WebForum "Dare to talk about obstetric violence". Organized by the Net of Nurses of Women Health in Countries of Portuguese Language on 16th December 2021[657].
- Baby Health Summit 6th Ed. (04 November 2023). Online Event. One communication on obstetric violence "Obstetric Violence: What we can control nowadays". This event was directed at women and was organized by healthcare specialists.[658]
- The big conference – Reborn in pregnancy, childbirth and parenthood. Online 09/09/2023

Training provided to professionals on the issue of obstetric and gynaecological violence

Despite the lack of 'legal classification' of obstetric and gynaecological violence, trainings were provided addressing legal issues related to obstetric violence (and using the terminology 'violence'). There were some trainings previously at the Legal and Judicial Training Unit (UNIFOJ; training unit of the Permanent Observatory of Justice (OPJ) of the Center for Social Studies (CES) of the University of Coimbra) in 2021, 2022, and now in 2024.
Through the Association for Women's Rights in Pregnancy and Childbirth, several trainings were organised addressing the legal issues linked to obstetric violence in 2023 (Judicial Studies Centre).
The interest behind these arose initially from the academia, including students, researchers, and practitioners.

In March 2024 Vânia Simões trained lawyers online (in a collaboration between the Portuguese Association for Women's Rights in Pregnancy and Childbirth and Portuguese Bar Association). She is also going to train the professionals to support women at the Portuguese Association for the Support of the Victim (APAV).

The Portuguese Association for Women's Rights in Pregnancy and Childbirth also provides training for health professionals on women's rights, but most of trainees are nurses and not medical staff.

To complement desk research, interviews were conducted with the following persons: Mia Negrão and Vânia Simões, lawyers specialised on obstetric and gynaecological issues.

A2.6 Sweden

Section I. Legal classification and access to justice

1.7. Legal classification of obstetric and gynaecological violence

Sweden has a patient law **PatientLag (2014:821)**[659] that applies to all types of health care and posits that "Healthcare must be provided with respect for the equal value of all people and for the dignity of the individual". Worth of note are:

656 https://www.centrodedireitobiomedico.org/encontros/viol%C3%AAncia-obst%C3%A9trica-bio%C3%A9tica-e-seguran%C3%A7a-da-paciente-uma-discuss%C3%A3o-luso-brasileira

657 https://resm-lp.esenfc.pt/pt/news/news-item/15-web-forum-js-daring-to-talk-about-obstetric-violence

658 https://www.netfarma.pt/redes-sociais-e-violencia-obstetrica-especialistas-analisam-principais-desafios-das-gravidas-no-baby-health-summit/

659 https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/patientlag-2014821_sfs-2014-821/

- Chapter 2. Availability, guaranteeing the right to a first assessment in primary care within three months.
- Chapter 3. Information, which includes patients' right to information about procedures.
- Chapter 4. Consent, which states that a patient must provide informed consent and has the right to withdraw consent at any time.
- Chapter 11. Comments, complaints and patient safety, stating that providers must have a system in place to support patient in filing a complaint.

In addition, Sweden has an abortion law (*Abortlag 1974:595)*[660] stating that all women have the right to free abortion before the end of the eighteenth week of pregnancy, after which, abortion may only be granted upon approval from The National Board of Health and Welfare under exceptional circumstances. In Sweden, there is no opt out right for health care professionals regarding abortion care. Therefore, physicians may risk prosecution if they deny patients abortion rights. Since 1971, there is a law stating that women have the right to effective pain relief during labour and birth[661].

1.2 Administrative and/or criminal penalties foreseen in cases of obstetric and gynaecological violence

Sweden does not usually handle maltreatment of patients through the court system. Prosecution and criminal penalties would only occur in rape and other serious cases, such as sexual harassment as well as if someone hinders a woman's legal right to abortion care. Rather, the Health and Social Care Inspectorate (IVO) is the appointed body dealing with patient maltreatment. So far, this system has generally worked well.

If a registered health care professional (i.e. physician, midwife, nurse etc.) have committed a serious error in their practice they may be issued with a warning, put on a probationary period, or have their registration for practice revoked. Following case reviews, all verdicts are given by an independent committee composed of independent experts with different skillsets and professions typically nominated from hospitals. Health care providers may also be deemed responsible and issued a fine. In these cases, they will need to write a plan of action to avoid that similar situations happen again in the future.

In January 2023, a woman sued Region Skåne, one of Sweden's 21 independent health care regions, for obstetric violence, specifically, in a case where a midwife did not ask for consent to perform fundal pressure. This is a unique case in Sweden and the outcome is not known yet; the court approved the case in September 2023 and the court proceedings will take place in 2024[662].

1.3 National complaint systems to report obstetric and gynaecological violence

1. Women who have experienced abuse or mistreatment can file complaints through three different systems:
2. **The Patient Advisory Committee**, an impartial group available in all 21 regions of Sweden that can help patients present their viewpoints or complaint to the clinic or unit in question and will ensure that they receive an answer.

The patient advisory committees are independent political bodies with the aim to assist patients in knowing their rights and help filing complaints. Every health care region (21 in Sweden) has at least one patient advisory committee.

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660 https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/abortlag-1974595_sfs-1974-595/

661 Socialutskottets betänkande i anledning av motioner om smärtlindring vid förlossning. Stockholm: Socialutskottet; 1971. Betänkande 1971: SoU40

662 TR-Beslut-angaende-medgivande-2023-09-27.pdf (centrumforrattvisa.se)

In region Västra Götaland there are five political committees (in total 60 appointed politicians based on the number of votes for their specific party in the election). The committee is responsible for budget, communicating about patient rights etc. In addition, everyday affairs and contact with patients is taken care of by 21 administrative staff and advisory consultants employed to assists patients. About 50% of the contact is by phone (mostly elderly and those who struggle with the language) and the other half is digital contact. Around 50% of those who contact them only want to put forward information about their case to help others in hopes of it not repeating itself, while the other half, around 5000 persons yearly, want to file an official complaint. The patient advisory consultant then files the complaint to the clinic (or other responsible party) and they then have four weeks to answer the complaint. The answer is normally:

1. Information about what happened (if there is a difference of opinion);

2. An apology;

3. A decision to start an investigation;

4. The clinic files a complaint with the Health and Social Care Inspectorate (IVO) based on their own wrongdoing.

Complaints filed through the Patient Advisory Committee are not publicly available but all complaints are registered in a system for the clinic to find general areas of improvement. The patient advisory committee puts together a yearly report shedding light to areas that need attention.

The Patient Advisory Committee is organised on a regional level and patients receiving publicly funded care have the right to turn to them to register a complaint. The hospital or clinic will then investigate and, if necessary, act. In serious cases, the most common action taken by the health care provider is to file a report with The Health and Social Care Inspectorate (IVO). They will investigate the case and write a verdict. The patient can also file a complaint directly with The Health and Social Care Inspectorate (IVO), but they will only investigate certain cases and might advise the patient back to the Patient Advisory Committee. The consultant's role is advisory but will help patient with contacts to gather some evidence if they are in a very exposed or difficult situation. They always use a licensed interpreter when needed and this is free of charge for the patient. This is a first step for patients and patients should file their complaint within 2 years. IVO requires that the case has been through this process before they take any steps further. The patient advisory consultant will assist in filling out forms to IVO and will gather everything that they have available to assists but the patient will have to mail the complaint themselves.

Privately financed care fall under The Health and Social Care Inspectorate (IVO) but not the Patient Advisory Committee. However, according to the patient law even privately financed healthcare needs to have a complaint system in place.

3. **LÖF,** patient insurance that compensates patients who suffered from avoidable injuries.
Löf is a mutual insurance company owned by all 21 regions in Sweden that gives out insurance according to the Patient Injuries Act[663] (updated through SFS 2021:364), which mandates all Swedish caregivers (public and private) to take out this insurance. The conditions for accepting or declining a claim are stated in the Patient Injury Act and the terms of compensation for avoidable injuries are stated in the Tort Liability Act of 1972 (SFS 1972:207)[664].
In Sweden, the patient files the complaint and it is up to LÖF to determine whether the injury could have been avoided or not. The patient does not have to prove causality themselves. No lawyers or courts are involved in the process, which is relatively quick.
In the years 2020 – 2022 Löf has received 5 400 claims regarding obstetric and gynaecological violence in patients 16 years and older, of which 1 900 were judged as avoidable and thus compensated. The

663 https://lof.se/filer/PSL-from-2021-07-01.pdf

664 https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/skadestandslag-1972207_sfs-1972-207/

remaining were judged as not avoidable by today's standards, and thus not compensated. It is difficult to state how many of these cases fall directly into the category obstetric and gynaecological violence as some cases might have happened with full information and consent.

4. **The Health and Social Care Inspectorate (IVO)**, a government agency responsible for supervising health care.

IVO is a government agency under the Ministry of Social Affairs. The agency is what is known as a single-authority agency, meaning that its Director-General is solely responsible for the operations before the government. The purpose of IVO's activities is to ensure that the healthcare and care provided in Sweden are of good quality and in accordance with laws and regulations. One of the starting points of its mandate is that it should focus on matters that are important to individuals and groups of people. As a general rule, its supervision should be risk-based and examine what is essential to contribute to safe and high-quality care. Supervision should also be conducted efficiently. IVO has an oversight council appointed by the government. The council's tasks are to exercise oversight and to advise the Director-General. The Director-General chairs the oversight council, and nine additional individuals are part of the council[665].

When a complaint is received by IVO, it is taken up by an assessment group consisting of inspectors and possibly additional expertise, and decisions are made about whether an investigation should be initiated or not. IVO's obligation to investigate complaints related to healthcare is regulated in Chapter 7 of the Patient Safety Act (PSL). Section 11 states that: "The Health and Social Care Inspectorate shall, if the affected healthcare provider has been given the opportunity to fulfil its obligations under Chapter 3, Section 8 b, investigate complaints concerning;
1. bodily or mental injury or illness that has arisen in connection with healthcare and that is enduring and not minor, or has led to the patient requiring significantly increased care or has died,
2. compulsory care pursuant to the Act (1991:1128) on Psychiatric Compulsory Care or the Act (1991:1129) on Forensic Psychiatric Care or isolation pursuant to the Communicable Diseases Act (2004:168), and
3. events in connection with healthcare that have seriously and negatively affected or threatened the patient's self-determination, integrity, or legal position."

The Health and Social Care Inspectorate may investigate complaints even if the conditions in the first paragraph are not met. Furthermore, it is stated that IVO may refrain from investigating complaints if the incident occurred more than two years ago, and IVO may refer the complaint to the healthcare provider if they have not had the opportunity to respond to the complaint[666]. The patient does not need to prove that the care has been deficient, but what has occurred should be evident from the complaint and how this has affected the patient and their health. It is based on the information in the complaint that IVO assesses whether any of the criteria in Chapter 7, Section 11 of the PSL are met.

To ensure that the decision is correct, it often requires several inspectors with different expertise to be involved in the preparation of the case. Fundamental to the handling of the case is the general investigative competence, as well as knowledge of the legal requirements in both common agency legislation and IVO-specific legislation. In addition, expertise in applying the patient perspective and specific nursing, medical, and dental expertise is needed, depending on the nature of the case. The different assessments in the complaint cases are mainly met by employed inspectors regarding, for example, specific nursing, general medicine, psychiatry, and dental care. For other medical areas, competence is usually provided by rapporteurs and external experts.

[665] https://ivo.se/om-ivo/uppdrag-organisation/

[666] For further information on when IVO may refrain from investigating complaints, see Chapter 7, Section 11 of the patient safety act (PSL).

If IVO considers that a complaint should be investigated, it requests the documentation needed to examine the incident, which may include patient records, statements from involved healthcare personnel and the responsible manager of the operation. When all documents have been received, an assessment is made of whether the care has been adequate or if there has been any deficiency in compliance with relevant regulations. Medical records carry significant weight in the assessments, but it also considers statements from parties involved and what the complainant states in their complaint. Subsequently, a "Draft Decision" is always sent to the complainant and the healthcare provider, as well as any other parties involved in the relevant complaint case. This allows the parties to provide their views on the proposal and submit any other relevant information. The potential comments received are taken into account and assessed. Then a decision is made and cannot be appealed, as stated in Chapter 10, Section 13 of the PSL.

Depending on the seriousness of any deficiencies and other circumstances affecting the assessment, IVO may decide on various sanctions. If the deficiencies are of a more serious nature, IVO may also instruct the healthcare provider to take measures, and such instruction may be accompanied by a penalty. If IVO receives information indicating significant risks to patient safety, IVO may initiate a self-initiated inspection. The inspection may result in the temporary or permanent closure of the operation. Based on information in a complaint under the Patient Safety Act, IVO may initiate an inspection case concerning licensed healthcare professionals. If IVO considers that licensed personnel have failed in their professional practice, there are different sanctions depending on the nature of the deficiency and how serious it is assessed to be. If IVO believes that there are grounds for a decision on probationary period, revocation of license, revocation of other authorization to practice a profession within healthcare, or restriction of prescription rights, IVO shall report this to the Health and Medical Responsibility Board (HSAN). This is regulated in Chapter 7, Section 30 of the PSL. It is then the responsibility of HSAN to make a decision on the matter. If healthcare personnel are reasonably suspected of having committed a crime punishable by imprisonment in their professional practice, IVO shall report this for prosecution. This is stated in Chapter 7, Section 29 of the PSL.

Section II. Awareness and prevention

1.8. Awareness

Research to address issues in relation to obstetric and gynaecological violence faced by specific groups of women is limited and mostly qualitative[667],[668]. In general, women from minorities, women who experience socially disadvantaged positions, women who do not speak the language, transmasculine men and those with low socio-economic status are at higher risk of mistreatment (including acts of obstetric and gynaecological violence). Unfortunately, there are no studies looking into obstetric and gynaecological violence in relation to intersectionality from a Swedish viewpoint. There is one study based on interviews specifically about obstetric violence[669].

For what concerns initiatives aiming at raising awareness, supporting and giving voice to women's experiences:

- Patient organisation *Birth rights Sweden*[670] is working to raise awareness on women's rights in childbirth. They launched a report in 2022 called 'Beyond the statistics' that collected 400 women's testimonies about maternal health, childbirth and mistreatment in Swedish labour and birth care[671].
- There is a social network on Instagram called 'be quiet, I'm giving birth' (*@tyst_jag_foder*) where women can share their stories about obstetric violence (1141 posts so far). There is also another Instagram account called 'everything is looking good' (@alltserfintut) where women with vaginal raptures share their stories (176 posts) of mistreatment (and sometimes mentioning of obstetrical and gynaecological violence).

1.9. Prevention

For what concerns initiatives on the issue from the side of healthcare providers, the Swedish Society of Obstetrics and Gynaecology has a lecture on obstetric violence available for clinicians on their homepage[672].

There are no protocols/guidelines regarding obstetric and gynaecological violence yet.

Intersectionality

In Gothenburg (Sweden's second largest city) and Region Västra Götaland, there is a publicly funded doula initiative targeting immigrant women who do not speak Swedish allowing them to have a so-called cultural doula as support and as an interpreter during their birth[673].

The initiative started in Gothenburg in 2008 through a one-time grant from the local public health committee in Västra Götaland[674]. The local health governance in Västra Götaland has since 2009 provided a yearly contract with funding for the doula project. The public non-profit organisations

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667 Falck, F., Frisén, L., Dhejne, C. & Armuand, G. (2021) 'Undergoing pregnancy and childbirth as trans masculine in Sweden: experiencing and dealing with structural discrimination, gender norms and microaggressions in antenatal care, delivery and gender clinics', International Journal of Transgender Health, 22:1-2, 42-53, DOI: 10.1080/26895269.2020.1845905

668 Essén B, Johnsdotter S, Hovelius B, Gudmundsson S, Sjöberg NO, Friedman J, Ostergren PO (2000) 'Qualitative study of pregnancy and childbirth experiences in Somalian women resident in Sweden. Br J Obstet Gynaecol.', 107: 1507-1512. 10.1111/j.1471-0528.2000.tb11676.x

669 Annborn, A., & Finnbogadóttir, H. R. (2022). Obstetric violence a qualitative interview study. Midwifery, 105, 103212.

670 https://www.birthrightssweden.se/

671 Birth Rights Sweden, *Rapport Mörkertalet Bortom statistiken. 400 kvinnors vittnesmål om mödrahälso-, förlossnings- och eftervården.* Available at:
https://drive.google.com/file/d/1S2cQalhFacVTFkXQUF6WWizfHd9stojU/view

672 https://www.sfog.se/media/338618/obstetriskt-vaald_perinatal-arg.pdf

673 https://www.doulakulturtolk.se/goteborg/

674 Answers based on interview with chairwoman of the non-profit organization "Tidigt föräldrastöd" Bodil Frey, 240212

organising the doulas has changed three times but since 2020 it is under the current organization 'Tidigt föräldrastöd'.

In the initial years, around 150 women per year received doula support, and since 2023, the funding has been extended and can support up to 300 women yearly. This service includes 1-2 visits during pregnancy to build a relationship between the doula and the woman. The doula supports at the hospital during active labour (not during early induction phases), then stays until everything has settled after the birth, typically the first two hours to help with initial breastfeeding and to provide support. This is followed by a home visit by the doula within the first week.

Primiparas and women newly integrated to the country are prioritised. However, if a woman is in an extra vulnerable situation (i.e. experiencing intimate partner violence) exceptions are made for women to have access to the service repeatedly. Women access the services through two different pathways: her midwife refers her to the service, or via direct contact with the doula (normally through word of mouth). Since all midwives are aware of the initiative, most (if not all) women in need are made aware of the service that is completely free of charge.

The doulas go through training given over two full weekends, but they also receive individual training in how Swedish health care systems work, patient rights etc. They also make sure that they understand the specific terms in Swedish and know how to translate this into their own language. The doula typically shares the original culture with the woman whom she is assisting. If they do not have the same cultural background, the doula will spend an extra visit with the woman during pregnancy to try and grasp her cultural norms. Doulas are invited to the operating room for vaginal births or c-sections if the woman going through the procedure wishes the doula to be there. Cultural doulas also act as interpreters as well.

The initiative expanded to Värmland in 2014, Umeå in 2015, Uppsala in 2018, and Stockholm in 2016. There are currently active programs in Umeå (region Västerbotten), led by midwife Maria Österberg and organised by the region itself[675]. In region Uppsala, women can seek help from culture doulas before and after they give birth to receive training and information, but they do not receive doula support during birth (approx. 100 women per year since 2018). In Region Värmland (Karlstad), the initiative was organised in a similar way to region Västerbotten until 2022, but now a non-profit organization has taken over and a reduced number of women can access support. In Stockholm, support is given to women by a non-profit organization, similarly to Gothenburg (about 1000 requests are received every year, and about 700 women receive support yearly). Region Halland had a doula initiative that was lost due to insufficient funding. Region Skåne was trying to implement it but did not receive funding.

To complement desk research, interviews were conducted with the following persons:

- Chairwoman of the non-profit organization "Tidigt föräldrastöd" Bodil Frey;

- Executive director of the Västra Götaland region patient advisory boards Susanne Tedsjö;

-Medical chief officer at Löf, Pelle Gustafsson

ANNEX 3. LIST OF EU AND INTERNATIONAL INTERVIEWS

- Agnieszka Bielska Decugniere from Directorate-General for Justice & Consumers (DG JUST), Unit D3. Gender Equality
- Cristina Fabre, Team Leader Violence Against Women at the European Institute for Gender Equality (EIGE)

[675] https://www.1177.se/en/Vasterbotten/other-languages/other-languages/graviditet---andra-sprak/kulturdoula--andra-sprak/

- Chiara Cosentino and Camille Butin, International Planned Parenthood Federation (IPPF) European Network
- Viktoria Vivilaki, President of the European Midwives Association (EMA) and Editor of the European Journal of Midwifery
- Jezid Miranda, Margit Steinholt, and Hasmik Bareghamyan, Committee on Health Systems Strengthening and Respectful Care, International Federation of Gynaecology and Obstetrics
- Prof Basil Tarlatzis, Former President of the European Board and College of Obstetrics and Gynaecology (EBCOG)
- Patrizia Quattrocchi, Professor of Cultural Anthropology and Senior Researcher in Medical Anthropology and Reproductive Health at the University of Udine, responsible for SAAGE's study on Obstetric Violence.

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This study presents an overview of how the issue of obstetric and gynaecological violence is currently being apprehended in the EU. Based on research carried out across the EU 27 Member States, it identifies issues and challenges; looks at the legal framework currently applicable to this form of violence; examines ongoing political and legal developments; and gathers initiatives carried out at the national level to improve understanding and prevention of this form of gender-based violence by healthcare professionals and society in general. Finally, it provides recommendations for different stakeholders.

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