

# Operationalizing a Human Rights-Based Approach to Address Mistreatment against Women during Childbirth

CHRISTINA ZAMPAS, AVNI AMIN, LUCINDA O'HANLON, ALISHA BJERREGAARD, HEDIEH MEHRTASH, RAJAT KHOSLA, AND ÖZGE TUNÇALP

## Abstract

A growing body of evidence reveals that the mistreatment of pregnant women during facility-based childbirth is occurring across the globe. As human rights bodies have increasingly recognized, numerous human rights are implicated in the context of mistreatment of women in childbirth, including the rights to be free from torture and other ill-treatment, privacy, health, non-discrimination, and equality. This paper builds on a previous paper published in this journal by Rajat Khosla, Christina Zampas, and others, and the new body of evidence describing the types of mistreatment that occur during childbirth, to unpack the drivers of the mistreatment of women during childbirth and how they are understood and addressed within human rights. Tracing recent developments, it examines how the United Nations Special Rapporteur on violence against women and the Parliamentary Assembly of the Council of Europe have addressed this issue. Understanding the drivers and human rights dimensions of the mistreatment of women during childbirth can contribute to accelerating progress toward universal health coverage, including access to reproductive health services, as mistreatment is a key barrier to women's access to such services. The article concludes by offering guidance to states on a human rights-based approach to addressing mistreatment against women during facility-based childbirth.

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CHRISTINA ZAMPAS is Associate Director of Global Advocacy at the Center for Reproductive Rights, New York, USA, and former consultant at the World Health Organization, Geneva, Switzerland.

AVNI AMIN is a Scientist at the Department of Sexual and Reproductive Health and Research, World Health Organization, Geneva, Switzerland.

LUCINDA O'HANLON is Advisor on Women's Rights at the Office of the United Nations High Commissioner on Human Rights, Geneva, Switzerland.

ALISHA BJERREGAARD is Schell Center Visiting Human Rights Fellow, Yale Law School, New Haven, USA.

HEDIEH MEHRTASH is a Research Consultant at the Department of Sexual and Reproductive Health and Research, World Health Organization, Geneva, Switzerland.

RAJAT KHOSLA is Human Rights Advisor, Department of Sexual and Reproductive Health and Research, World Health Organization, Geneva, Switzerland.

ÖZGE TUNÇALP is a Scientist at the Department of Sexual and Reproductive Health and Research, World Health Organization, Geneva, Switzerland.

Please address correspondence to Özge Tunçalp. Email: [tuncalpo@who.int](mailto:tuncalpo@who.int).

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## Introduction

Worldwide, about 140 million women give birth every year.<sup>1</sup> For health care facilities, in addition to providing the high-quality clinical care specific to labor and childbirth, this means making sure that the manner in which care is delivered is woman centered and respectful and protects and promotes their rights. Ensuring a continuum of care, regular monitoring and documentation of clinical events, and clear, empathetic, and respectful communication between health care providers and clients is essential. In addition, women must be given the information, choices, and support they need to make informed decisions, and a referral plan must be in place should more advanced medical care become necessary. These are all essential elements of good-quality labor and childbirth care that every woman and newborn should receive.<sup>2</sup>

Within the World Health Organization's (WHO) quality of care framework for maternal and newborn health, experience of care—which includes treatment with respect and dignity, effective communication, and emotional support—is an essential component of the provision of quality care. With an increased body of evidence, there has been a growing recognition that mistreatment of pregnant women during facility-based childbirth is occurring across the globe.<sup>3</sup> While various terms (for example, “obstetric violence,” “dehumanized care,” and “disrespect and abuse”) have been used to describe the phenomenon, in this paper we use the term “mistreatment of women during childbirth,” which is based on a mixed-methods review capturing a range of experiences of women and health care providers, and which takes into account acts or behaviors that constitute a range of forms of abuse and violence, as well as practices that reflect health system limitations and poor quality of care.<sup>4</sup>

This paper builds on a previous paper by Khosla, Zampas, and others, and the new body of evidence describing the types of mistreatment that occur during childbirth, to unpack the drivers of the mistreatment of women during childbirth and how they are understood and addressed within human rights.<sup>5</sup> Tracing recent developments, it examines how United Nations (UN) human rights bodies, in-

cluding the Special Rapporteur on violence against women, and the Parliamentary Assembly of the Council of Europe, have addressed this issue.

Understanding the drivers and human rights dimensions of the mistreatment of women during childbirth can help states meet their high-level political commitment to ensure universal access to quality health care, including reproductive health services. Under the 2030 Agenda for Sustainable Development, which is designed to “leave no one behind,” states have committed to achieving the goals of healthy lives and gender equality by ensuring access to quality maternal health care and guaranteeing women's and girls' reproductive autonomy.<sup>6</sup> States have also committed to “end all forms of discrimination against all women and girls everywhere,” including through legislative and policy reform.<sup>7</sup>

Universal health coverage (UHC) is the pillar of Sustainable Development Goal 3. High-level commitments and a call to action on UHC occurred at the UN General Assembly in 2019.<sup>8</sup> Member states agreed to accelerate progress toward UHC, including sexual and reproductive health services and reproductive rights, with a focus on poor, vulnerable, and marginalized individuals and groups. Achieving these high-level political commitments requires states to implement a human rights-based approach to addressing the mistreatment of women during childbirth.

## Methods

Building on the data collected for the previous paper by Khosla and colleagues, this paper scoped relevant public health studies and WHO guidelines published since 2016. Additional references were added based on oral and written contributions made at WHO's expert group meeting with the UN Special Rapporteur on violence against women, held in Geneva, Switzerland, in April 2019. Similarly, building on the research findings of the previous paper, which covered normative developments in human rights standards between 2000 and 2015, recent human rights standards were identified by a review of reports, general comments, and decisions

issued by UN and regional human rights bodies between 2016 and 2019 regarding the mistreatment of women during childbirth.

## Public health evidence on the types of mistreatment of women during childbirth

There has been an evolving body of scientific research on the mistreatment of women during facility-based childbirth. Yannick Jaffre and colleagues published a paper describing this emerging phenomenon in Niger in 1994.<sup>9</sup> In 1998, Rachel Jewkes and colleagues published a qualitative study on why nurses abuse patients in South African obstetric wards. Jewkes highlighted the complex interplay of institutional practices, professional insecurities, coercive control, and power dynamics present during facility-based childbirth; in the meantime, in Latin America, research and advocacy efforts were informing the development of a legal framework addressing “obstetric violence.”<sup>10</sup> In 2010, Diana Bowser and Kathleen Hill published their seminal landscape analysis on disrespect for and abuse of women during childbirth.<sup>11</sup> Their work informed our understanding of the definition, scope, contributors, and impact of disrespect and abuse in childbirth.

In 2014, noting that “a growing body of research on women’s experiences during pregnancy, and particularly childbirth, paints a disturbing picture,” WHO issued a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth. In its statement, endorsed by over 90 civil society and health professional organizations, WHO highlighted that

*[s]uch treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue.*<sup>12</sup>

This “has now sparked new empirical research across different continents, an advocacy agenda and a growing number of interventions.”<sup>13</sup> A 2015

systematic review that synthesized the existing global qualitative and quantitative evidence on the mistreatment of women during childbirth in health facilities identified 65 studies containing research findings from 34 countries.<sup>14</sup> This review, as well as other studies, categorized the types of mistreatment experienced by women during facility-based childbirth.<sup>15</sup> They also revealed that mistreatment is more likely to occur against, for example, women from minority racial, ethnic, and religious groups; women of lower socioeconomic status; migrant women; women with disabilities; adolescents; women living with HIV; and unmarried women—women who experience intersectional discrimination on multiple grounds.

Despite the growing recognition of this issue, data collection on experiential aspects of facility-based childbirth has been limited by the lack of reliable and valid standardized tools to quantitatively measure the mistreatment of women across global settings. To address this critical gap, WHO led a multi-country mixed-methods study in four countries (Ghana, Guinea, Myanmar, and Nigeria) to develop two measurement tools (labor observation and community survey) and to measure how women are treated during facility-based childbirth across countries.<sup>16</sup> The evidence indicated that a little more than 30% of the study population experienced mistreatment during childbirth in health facilities. The study showed that women were at an increased risk of experiencing physical and verbal abuse between 30 minutes before birth until 15 minutes after childbirth. Moreover, younger, less educated women were most at risk, suggesting that age and lack of education compounded the discrimination faced by some subgroups of women.<sup>17</sup>

Additionally, it is important to note that women who experience mistreatment during childbirth may underreport these instances. A mixed-methods study in Tanzania, comparing the prevalence of mistreatment during childbirth as measured through observation and self-reporting, found a huge disparity between these two measures both during the baseline and endline measurements (baseline: 69.83% observation versus 9.91% self-reporting; endline: 32.91% observation versus 7.59%

self-reporting). This suggests that mistreatment can be internalized and normalized by users and providers alike.<sup>18</sup> This does not mean that the mistreatment they experienced should be ignored or is not important; rather, it highlights the need to be nuanced in the interpretation of evidence, as it appears that women have such low expectations of care that they may be satisfied with poor-quality care that includes mistreatment.<sup>19</sup>

### Understanding the human rights dimensions of mistreatment of women during facility-based childbirth

Numerous human rights are implicated in the context of mistreatment of women in childbirth, including the right to be free from violence, the right to privacy and non-discrimination, and the right to the highest attainable standard of health.<sup>20</sup> Human rights organizations have published reports documenting the abuses that women and girls experience during childbirth in health care facilities around the world.<sup>21</sup> The impact of these rights violations on women's health, well-being, choices, and access to reproductive health services, as well as strategies for how to prevent these abuses, needs further and careful examination.<sup>22</sup>

#### *A continuum of human rights violations*

Childbirth and parenting are life-changing experiences for all women, regardless of their background, culture, or location, as they affect every facet of their lives, including education, employment, family life, and health. While the focus of this paper is on mistreatment against women during facility-based childbirth, it is critical to contextualize these abuses against a wider backdrop of discriminatory laws, policies, and practices faced by women and girls globally. More broadly, these abuses occur as part of a continuum of stigma and discrimination against women in society and implicate a range of human rights, including those related to housing, employment, and the exercise of freedom of expression and association. These abuses are also experienced by women and girls in the context of other sexual and reproductive health care, including abortion, fertil-

ity treatments, and contraception.<sup>23</sup> Human rights bodies have consistently found states in violation of numerous human rights—including the rights to be free from torture and other ill-treatment, privacy, health, and equality—when women are denied their autonomy in these contexts.<sup>24</sup>

#### *Types of mistreatment*

**Physical and verbal abuse.** Physical abuse during childbirth may entail beatings, hitting, slapping, kicking, and pinching by nurses, midwives, or doctors.<sup>25</sup> One woman from Ghana explained:

*When I was due for labour and was asked to push, I couldn't push and the nurse beat me very well. She used a cane to whip me so I could push, but I told her I was tired but she insisted I should push. So she really whipped me with the cane and later used her hand to hit my thigh. There I became conscious and was able to push.*<sup>26</sup>

Other forms of physical abuse include providers conducting painful and medically unnecessary vaginal exams during labor.<sup>27</sup>

Women have also reported sexual abuse by health care providers during childbirth. One study, which focused on women's experience of mistreatment during childbirth in a hospital in Nigeria, found that 2.0% of women interviewed reported being sexually abused by a health worker.<sup>28</sup>

Studies and human rights reports have documented abusive, discriminatory, rude, and judgmental language by health care providers toward women in labor. Women report being mocked, scolded, insulted, and yelled at by providers.<sup>29</sup> A recent report on Slovakia found that medical personnel often made derogatory remarks toward Roma women about how frequently they had sexual intercourse and the number of children they had, based on the negative gender stereotype that Roma women are "promiscuous."<sup>30</sup> In Brazil, it has been reported that "one of the most common insults was 'Na hora de fazer não chorou' ('You didn't cry like that when making the baby')."<sup>31</sup>

Unmarried adolescent girls face verbal abuse during childbirth because of their age and the stigma of being unmarried.<sup>32</sup> Fear of such discrimi-

nation is a powerful disincentive to deliver in health facilities in Ghana, Sierra Leone, and Tanzania.<sup>33</sup> Women have also reported experiencing threats of treatment being withheld or “threats of beatings if the woman was noncompliant ... and blame for their baby’s or their own poor health outcomes.”<sup>34</sup>

These practices violate women’s right to be free from gender-based violence, as well as their rights to health and privacy. They may also constitute violations of the right to be free from torture and cruel, inhuman, or degrading treatment.<sup>35</sup>

**Absence of informed consent, abuse of the doctrine of medical necessity, and denial of women’s choices.** Informed consent to medical care is fundamental in both law (including human rights law) and ethics. Patients have the right to receive information and ask questions about recommended treatments so that they can make informed and well-considered decisions about care.

The information provided by the health provider to the patient should emphasize the treatment’s advantages and disadvantages, health benefits, risks, and side effects, and it should enable a comparison of various treatment options. Information should be provided in a manner and language that is understandable, accessible, and appropriate to the needs of the individual making the decision. Persons with disabilities should be provided with all the necessary support and respect for making their decisions, including by ensuring that decisions that should be made using the process of supported decision-making are not de facto substituted decisions.<sup>36</sup> The International Federation of Gynecology and Obstetrics (FIGO) recognizes that the implementation of informed consent is an obligation for providers, despite the fact that at times it can be challenging and time consuming.<sup>37</sup>

Violations of the right to informed consent occur in a number of contexts related to labor and childbirth. These include over-medicalized and unconsented-to procedures during and immediately after childbirth; coerced procedures and breaches of privacy during women’s stay in health facilities; insufficient information for women to make informed decisions; and health care providers’ disregard for

women’s preferences in the provision of care.<sup>38</sup>

Women have also been coerced into consenting to sterilization during childbirth.<sup>39</sup> For example, women living with HIV in Kenya have reported being asked to sign consent forms for sterilization while in labor, and others have been misinformed about the procedure or threatened with not being provided baby formula or antiretroviral medications if they refused to consent to sterilization.<sup>40</sup>

These practices deter women from seeking and using maternal health care services and erode their trust in the health care system. They also have significant health impacts on women and their newborns. Routine abuse may also mean that “both health workers and patients may have come to expect and accept the poor treatment of women as the norm.”<sup>41</sup> In addition to violating ethical principles for providers, these practices violate numerous human rights.<sup>42</sup>

**Denial of care, segregation, removal, and detention.** In the context of facility-based maternity care, women experience discriminatory denials of care, segregation, involuntary separation from their newborns, and detention. For example, women who present at a health care facility during labor may be refused care entirely, on the grounds of lacking the economic means or due to their HIV status. Women have also reported being refused pain medication or anesthesia during childbirth because of an inability to pay. In addition to deliberate refusals to provide pain relief, structural barriers can also be responsible for the failure to provide pain management. For example, pain medication is also not always available in certain health care settings, due to stockouts.<sup>43</sup> Women are also subjected to deliberate delays in care, including stitching after childbirth, and serious neglect by providers, sometimes to the point of death or severe disability.<sup>44</sup> In some settings, migrant or refugee women are “expected to pay higher rates for services or to pay bribes” in order to receive care.<sup>45</sup>

Some maternity hospitals segregate women within the facility based on race, ethnicity, or medical condition, such as HIV. For example, Roma women in Slovakia are placed in “Roma-on-

ly” rooms in maternity hospitals, which are often substandard.<sup>46</sup> Women may also face the removal of their infants from their care against their will—with no legitimate health-related justification.<sup>47</sup>

The post-childbirth detention of women and their newborns in health care facilities because of their inability to pay hospital fees is another example of abuse that has been documented worldwide.<sup>48</sup> In Kenya, detained women and their infants have been made to sleep on the floor, denied adequate food, and watched over by guards.<sup>49</sup>

These practices violate the right to be free from discrimination and may also constitute violations of the right to be free from torture and cruel, inhuman, or degrading treatment.<sup>50</sup>

### Drivers of mistreatment against women during facility-based childbirth

Efforts to prevent women from exerting full control over their bodily autonomy and decision-making are reflected in both law and practice.<sup>51</sup> Many states have failed to put in place a protective legal and policy framework to ensure that women receive care that is respectful of their needs and desires and that prevents and addresses mistreatment during childbirth. This has slowly begun to change. For example, in recent years, some countries have passed laws or issued policies that expressly allow a woman to be accompanied by a companion of her choice during childbirth and have developed broader legislation encouraging the “humanization” of childbirth.<sup>52</sup> However, other laws contribute to an environment of violence and mistreatment. These laws include spousal or third-party consent laws, and laws that deprive women with disabilities of their legal capacity, replacing women’s decision-making with that of a family member or other institutional authority. They also encompass laws that recognize fetal personhood, prioritizing the fetus over the life and health of the pregnant woman.

These practices are often justified in the name of tradition, culture, and religion—grounds that human rights bodies have expressly stated may “not [be] used to justify violations of women’s right to equality before the law and to equal enjoyment

of all [] rights.”<sup>53</sup> Underpinning these laws and practices are harmful gender stereotypes. In addition, the power imbalance often embedded in the provider-patient relationship further reinforces the denial of women’s reproductive autonomy. Health systems conditions and constraints also play a role in fueling the mistreatment of women during facility-based childbirth.

It is important to recognize that different types of mistreatment, and even the same types, may have different causes depending on the context, even in the same facility.

### *Harmful gender stereotypes*

Stereotypes about women’s decision-making competence, women’s natural role in society, and motherhood often fuel the laws and practices denying women’s reproductive autonomy during childbirth. These stereotypes arise from strong religious, social, and cultural beliefs and ideas about sexuality, pregnancy, and motherhood.<sup>54</sup> The stereotype that women are overly emotional and vulnerable and are therefore incapable of making rational decisions about their medical care is particularly pervasive. In the reproductive health context, this stereotype is compounded by stereotypes depicting women’s primary role as mother, child bearer, and caregiver.<sup>55</sup> These gender stereotypes create the ideal of the “self-sacrificing mother.”<sup>56</sup>

UN human rights bodies are beginning to recognize the harms of such stereotypes.<sup>57</sup> The CEDAW Committee, in *L.C. v. Peru*, affirmed that this “self-sacrificing mother” stereotype “understands the exercise of a woman’s reproductive capacity as a duty rather than a right.”<sup>58</sup> As a result, any pain or suffering that accompanies the child bearing role is considered natural and expected, and health care providers may therefore not offer women the same pain management during labor and childbirth as they would offer to other patients in pain.<sup>59</sup>

The UN Working Group on the issue of discrimination against women in law and in practice has recognized that “unnecessary medicalization ... [has] functioned as [a] form of social control exercised by patriarchal establishments to pre-

serve the gender roles of women.”<sup>60</sup> The Special Rapporteur on torture has also noted that in many countries, women seeking maternal health care face a high risk of ill-treatment, particularly immediately before and after childbirth, and that this “mistreatment is often motivated by stereotypes regarding women’s childbearing roles and inflicts physical and psychological suffering that can amount to ill-treatment.”<sup>61</sup> Relatedly, stereotypes can also negatively affect how women’s bodies are perceived, leading to sometimes unnecessary interventions, such as episiotomies, C-sections, or symphysiotomies.<sup>62</sup>

All the stereotypes mentioned above interact such that health care providers in some cases do not seek women’s informed consent, instead substituting their beliefs about the best course of treatment for those of the women. Such treatment is often justified on the basis of the purported interests of the fetus or the best interest of the woman, but it reinforces the stereotype that women are unable to make informed decisions and reduces them to objects of intervention without agency.<sup>63</sup>

### *Power dynamics*

Interpersonal and systemic power dynamics in the provider-patient relationship are other root causes of mistreatment. As noted by Lynn Freedman, understanding power is helpful to understanding how mistreatment occurs and how to address it. Freedman classifies such power as visible (formal, observable powers such as laws and regulations), hidden (powers beyond professional standards of care, which encompass all the actors in health settings, such as guards and food service delivery personnel), or invisible (norms that operate subconsciously and are internalized by providers or women themselves).<sup>64</sup> Thus, power dynamics can be both interpersonal and systemic (see section below on weak health systems).

In the context of the provider-patient relationship, the provider has the power of authoritative medical knowledge and the social privilege of medical authority, while the patient is largely dependent on the provider for information and care.<sup>65</sup> The UN Special Rapporteur on the right to health has de-

scribed the right to autonomy over decision-making as a counterweight to “the imbalance of power, experience and trust inherently present in the doctor-patient relationship.”<sup>66</sup> This imbalance can be especially acute in childbirth, as women may experience a heightened sense of vulnerability during labor, childbirth, and the immediate post-partum period, including because women who give birth, regardless of the circumstances, are often grateful if the outcome is a healthy infant. The power dynamics between provider and patient are also a product of their specific social context: institutional maternity care “tracks lines of social disadvantage,” mirroring “the inequalities of the society in which it functions.”<sup>67</sup>

This imbalance is particularly apparent in providers’ abuse of the doctrine of medical necessity to justify mistreatment and abuse during childbirth.<sup>68</sup> The forced sterilization of women following childbirth is one such example, with providers justifying performing the procedure without the woman’s consent as somehow necessary for the best interests of the woman.<sup>69</sup> Providers also withhold information or mislead women into consenting to sterilization, acting, in the words of the European Court of Human Rights, with “gross disregard for her right to autonomy and choice as a patient.”<sup>70</sup> Although providers do not necessarily have the intent to ill-treat their patients, “medical authority can foster a culture of impunity, where human rights violations do not only go unremedied, but unnoticed.”<sup>71</sup>

### *Weak health systems*

Health systems need to be better able to prevent and effectively respond to mistreatment against women.<sup>72</sup> Health system conditions and constraints play a role in driving mistreatment against women during childbirth.<sup>73</sup> States have an obligation to ensure the availability and quality of maternal health care facilities, goods, and services, as well as the adequate training of providers.<sup>74</sup> To fulfill this obligation, states “must devote the maximum available resources to sexual and reproductive health,” adopt a human rights-based approach to identifying budgetary needs and allocations, and

ensure accountability.<sup>75</sup> Human rights bodies have recognized that a state's failure to dedicate adequate resources to women's specific health needs is a violation of women's right to be free from discrimination and that it requires effective mechanisms for redress.<sup>76</sup>

The "entrenched gender-based discrimination within the largely female health workforce, who experience gender pay gaps, irregular salaries, lack of formal employment, sexual harassment, and inability to participate in leadership and decision-making" also plays a role in normalizing and thereby perpetuating mistreatment.<sup>77</sup> A 2016 WHO global survey of midwives "reveal[ed] that too often midwives report their efforts are constrained by unequal power relations within the health system. Many midwives also face cultural isolation, unsafe accommodation and low salaries."<sup>78</sup>

Twelve UN agencies, including WHO, have therefore urged states to pay "particular attention ... to the gendered nature of the workforce" and ensure gender-sensitive facility-level policies, as well as health professional regulations operationalizing decent work and formal employment of the health work force, in order to address discrimination against women health workers in health care settings and to alleviate stressful work conditions that can foster mistreatment.<sup>79</sup> They have also recommended that states support health workers "in upholding their legal and ethical responsibilities, including with respect to advancing human rights, and that their role as human rights defenders [] be protected."<sup>80</sup>

### Using global health and human rights mechanisms to address mistreatment during childbirth: The way forward

WHO and UN and regional human rights experts and bodies have called attention to the mistreatment of women during childbirth and pushed for states to take steps to ensure that women receive dignified, respectful health care during labor and childbirth.<sup>81</sup>

The work on the mistreatment of women during childbirth has sparked new empirical re-

search across different continents, an advocacy agenda, and a growing number of interventions. In 2018, for example, synthesizing qualitative evidence, researchers developed domains of what constitutes respectful maternal care, expanding on the concept of mistreatment.<sup>82</sup> This led to WHO publishing global recommendations on intrapartum care for a positive childbirth experience that included specific recommendations on respectful maternity care.<sup>83</sup>

International human rights bodies have played a vital role in setting standards and monitoring human rights violations in the context of maternal health, including childbirth.<sup>84</sup> For example, in 2012, the Office of the United Nations High Commissioner for Human Rights issued technical guidance on the application of a human rights-based approach to the implementation of policies and programs to reduce preventable maternal morbidity and mortality.<sup>85</sup> And in 2011, the CEDAW Committee issued its decision in *Alyne da Silva Pimentel Teixeira v. Brazil*, considered the first decision where a government was held accountable for a preventable maternal death by an international treaty body.<sup>86</sup>

Although many human rights bodies have denounced the range of abusive practices as violations of human rights, their decisions and statements have often been siloed. UN mechanisms and Special Procedures mandate-holders have looked at specific sets of abuses, such as forced sterilization and the shackling of incarcerated or detained women during childbirth, leaving many types of mistreatment, many of which are often normalized, "unaddressed or inadequately analysed under international human rights law."<sup>87</sup> In particular, they have not necessarily articulated the rights violations in a way that acknowledges the broader backdrop of abuse and mistreatment within the context of childbirth and sexual and reproductive rights more generally.<sup>88</sup> In addition, courts and human rights bodies have not clearly articulated that this mistreatment is fueled by intersectional discrimination and experienced disproportionately by particular groups of women, including women with disabilities, migrants, economically disadvantaged women, adolescents, indigenous or other ethnic



minorities, LGBTI persons, and women living with HIV, among others.<sup>89</sup>

In 2019, two important human rights mechanisms undertook the first comprehensive and robust examinations of the issue of mistreatment during childbirth. First, the UN Special Rapporteur on violence against women identified this issue as a priority and presented a thematic report on the topic to the 74th UN General Assembly on October 4, 2019.<sup>90</sup> WHO supported the mandate in preparation of this report by organizing an expert meeting in April 2019 and by producing a background document that included recommendations. Second, the Council of Europe Committee on Equality and Non-Discrimination prioritized this topic and prepared a report that informed the Council of Europe's Parliamentary Assembly Resolution, passed on October 3, 2019, calling on member states to address this issue.<sup>91</sup>

These high-level efforts underscore the global nature of this challenge and highlight the need for concerted global action to address the mistreatment of women during childbirth.

## Conclusion

Women have a right to dignified, respectful health care, free from discrimination and coercion, throughout pregnancy and childbirth, as protected in international and regional human rights law and standards. States have a due diligence obligation to prevent, investigate, and punish human rights violations during childbirth, including those acts which constitute mistreatment, whether by state or non-state actors. Moving forward, it is important to ensure an enabling legal and policy environment, such that women-centered care during childbirth is part of the implementation of all relevant policies and programs. This includes efforts to implement states' 2019 commitment to accelerating the provision of universal health coverage under the Sustainable Development Goals.

Key conclusions from WHO's 2019 expert meeting provide some guidance to states and other stakeholders on how to apply a human rights framework to address mistreatment during

childbirth. This expert guidance closely tracks the recommendations included in the UN Special Rapporteur on violence against women's report and the Parliamentary Assembly of the Council of Europe's resolution.<sup>92</sup> The WHO expert meeting called for states to do the following:

- Ensure compliance with international and regional human rights obligations and standards that protect women's rights in the context of childbirth.
- Review and strengthen laws and policies to prohibit the mistreatment of women during pregnancy and childbirth. Laws and policies must ensure autonomy in health care decision-making; guarantee free and informed consent, privacy, and confidentiality; prohibit mandatory HIV testing; prohibit screening procedures that are not of benefit to the individual or the public; ban involuntary treatment and mandatory third-party authorization and notification requirements; and explicitly guarantee women's rights to respectful maternity care and a birth companion of choice.
- Strengthen capacities to address multiple forms of discrimination that women experience during childbirth, including discrimination based on age, race, socioeconomic status, HIV status, education, disability, sexual orientation, and gender identity.
- Allocate adequate funding, staffing, and equipment for maternity care wards and facilities and ensure that the cost of health care financing "is not borne disproportionately by the poor."
- Ensure that the rights of health workers are fully protected, respected, and fulfilled and that health workers are free from discrimination and violence in the workplace.
- Ensure that policies, programs, and budgets promote health workforce educational and career development opportunities, pre-service education, and in-service training of all health workers on respectful maternal care, in accordance with WHO norms and guidelines.

- Implement evidence-based practices and guidelines, monitoring, and evaluation, including WHO's norms and standards related to respectful maternity care, intrapartum care, and violence against women.
- Ensure meaningful participation by women and civil society in all levels of legal and policy decision-making, and in monitoring.
- Strengthen mechanisms for the systematic reporting, monitoring, and evaluation of mistreatment of women during childbirth in public and private health care facilities.
- Strengthen the capacity of regulatory bodies and health professional associations, including national human rights institutions, to exercise oversight over public and private birthing facilities.
- Ensure accountability for the mistreatment of and violence against women during childbirth.
  - Create, strengthen, and fund accountability mechanisms to foster the accountability of multiple actors at various levels, both within health care settings and within the justice system.
  - Ensure that victims of rights violations are provided remedies—which may take the form of restitution, compensation, satisfaction, or guarantees of non-repetition—by both state and non-state actors.
  - Guarantee full and fair investigations into allegations of mistreatment and violence against women during childbirth, including by ensuring that the burden of proof is on the state and not the victim of the violation.
  - Raise awareness among lawyers, judges, and the public about the applicability of claims relating to women's sexual and reproductive rights in the context of childbirth to ensure the effective use of remedies in these cases.

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## A note on terminology

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

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