



Convention on the Elimination of All Forms of Discrimination against Women

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Committee on the Elimination of Discrimination against Women

Views adopted by the Committee under article 7 (3) of the Optional Protocol, concerning communication No. 149/2019^{*,**}

<i>Communication submitted by:</i>	N.A.E. (represented by counsel, Francisca Fernández Guillén and Marina Morla González)
<i>Alleged victim:</i>	The author
<i>State party:</i>	Spain
<i>Date of communication:</i>	10 November 2018
<i>References:</i>	Decision taken pursuant to rule 69 of the Committee's rules of procedure, transmitted to the State party on 9 September 2019 (not issued in document form)
<i>Date of adoption of views:</i>	27 June 2022

1.1 The author of the communication is N.A.E., a Spanish national born on 12 September 1986. The author maintains that Spain violated her rights under articles 2, 3, 5 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women owing to the obstetric violence she experienced in hospital during childbirth. The Convention and the Optional Protocol thereto entered into force in the State party on 4 February 1984 and 6 October 2001, respectively. The author is represented by counsel.

* Adopted by the Committee at its eighty-second session (29 June–9 July 2022).

** The following members of the Committee participated in the examination of the present communication: Gladys Acosta Vargas, Hiroko Akizuki, Tamader Al-Rammah, Nicole Ameline, Marion Bethel, Leticia Bonifaz Alfonso, Louiza Chalal, Corinne Dettmeijer-Vermeulen, Naéla Mohamed Gabr, Hilary Gbedemah, Nahla Haidar, Dalia Leinarte, Rosario G. Manalo, Lia Nadaraia, Bandana Rana, Rhoda Reddock, Elgun Safarov, Natasha Stott Despoja and Franceline Toé-Bouda. In accordance with rule 60 (1) (c) of the Committee's rules of procedure, Ana Peláez Narváez did not participate in the examination of the communication.



1.2 Between 21 May 2020 and 30 June 2020, the Committee received 11 submissions from third parties,¹ which were transmitted to both parties for their comments.

Facts as submitted by the author

Pregnancy, delivery by major abdominal surgery (caesarean section) and post-partum

2.1 During the 25-year-old author's first pregnancy, which had been monitored and healthy throughout, she and her partner submitted a birth plan to the public hospital of Donostia, which is run by the Basque Health Service. In the plan, they stated that they did not want drugs to be administered to induce or accelerate labour, that any decisions taken by the medical staff should have their consent, that, if a caesarean section were necessary, the baby should be with its mother immediately following birth or with its father if the author had to remain in the operating room, and that the baby should not be bottle-fed.

2.2 At 8 a.m. on 9 July 2012, at 38 weeks of pregnancy, the author went to the hospital because her waters had broken. Upon her arrival, a midwife performed the first digital vaginal examination² to check whether the sac "really was broken".

2.3 The hospital's protocol sets out a waiting period of 24 hours before inducing labour. At 4 p.m. the same day, however, a gynaecologist informed the author that labour would be induced because, in the gynaecologist's words, "we do not induce at night". The author claims that there was no medical need to induce labour because, after she was admitted, she had felt regular spontaneous contractions, which meant that the labour was progressing. According to the author, instead of taking an expectant management approach for at least 24 hours, which would have enabled cervical ripening³ and facilitated natural labour, the hospital's preference was to induce labour for the convenience of the attendants. At 5.10 p.m. on 9 July 2012, 14 hours after her waters had broken, her labour was medically induced using an injection of oxytocin. She points out that this not only undermined her safety and that of her unborn child, but also went against the hospital's own protocol, which sets out a waiting period of 24 hours before inducing labour.

2.4 The author did not consent to the induction of labour; her repeated requests for information on the risks and alternatives went unanswered.

2.5 Before labour was medically induced, the author requested permission to eat, which was denied by the hospital despite the fact that the Spanish Ministry of Health, in its care guidelines for normal labour, recommends that food be provided and states that energy sources must be guaranteed to ensure maternal and fetal well-being.

2.6 At 5 p.m., minutes before the induction, a trainee student performed a second digital vaginal examination, giving the impression that she did not really know what she was doing, and caused the author a great deal of pain. Not only had the author

¹ From, in chronological order, the Centre for the Monitoring of Obstetric Violence in Spain; María Fuentes Caballero from the Artemisa Health Centre (Cádiz); the Study Centre for Human Rights and Humanitarian Law of the Panthéon-Assas University (Paris); the Migjorn Childbirth House (Barcelona); the Birth Rights Platform; the Association of Home Birth Midwives of Catalonia; the Centre for the Monitoring of Obstetric Violence in Chile; the Home Birth Association; the Balearic Childbirth Association; the Information Group on Reproductive Choice (Mexico); and the Network for the Humanization of Labour and Birth (Brazil). The main submissions are discussed in paragraphs 6 to 12.

² A digital vaginal examination consists in the insertion of one or more fingers into a pregnant woman's vagina to measure the extent of dilation.

³ Procedure aimed at facilitating the process of softening and opening the cervix.

requested that she be assisted by the minimum number of staff, but the Patient Autonomy Act⁴ also provides for scrupulous respect for personal privacy and individual freedom.

2.7 Between 8 p.m. on 9 July and 7.30 a.m. on 10 July, a further seven digital examinations were performed.

2.8 At 9.30 a.m. on 10 July 2012, a tenth digital vaginal examination was performed and, despite the fact that the fetal monitoring recordings were fine, the midwife informed the author that a caesarean section was being considered because the labour was supposedly “stalled”. The author asked the midwife to assess dilation; when the midwife determined that she was now 7 centimetres dilated and the baby had moved further down, the author tearfully asked her to inform the doctors. When the doctors arrived, however, they had already made the decision, stating “yes, a caesarean section and that’s that”. When the author asked for information, the doctor did not provide any, but rather spoke to her like a child, replying “calm down, I’m going to take care of you”.

2.9 At 10 a.m., the students began the operation without the author’s consent. The doctors did not allow the author’s husband to be present. According to the author:

I was placed on the operating table like a doll. No one introduced themselves; no one spoke to me; no one looked me in the face. No one bothered to try to calm me down. I was crying a lot. They placed my arms out to the sides. The operating room was full of people; it was like a public square. They ignored me and shouted to each other “the placenta container is missing” and “where is the baby’s tag?”. I was there alone and naked, and people were coming and going, the door kept opening and closing [...]. They were talking among themselves about their business, what they had done over the weekend; they were talking without caring that I was there and was about to give birth to my son – my son who could only be born once, and they did not let me experience it.

2.10 Despite the fact that, according to Spanish health regulations, no patient may be used in a training programme without prior consent, a doctor guided the author’s surgeons through all the steps, telling them how to cut and what they were cutting – details that the author would have preferred not to hear.

2.11 The author’s son was born at 10.12 a.m. After the caesarean section had been performed, the protocol was once again not followed. According to the protocol, the newborn should remain with its mother from the moment she is responsive in order to initiate breastfeeding and skin-to-skin contact between mother and child, which improves the baby’s heart rate, temperature, blood glucose, immune system and sleep. However, the baby was separated from his mother to be taken to the paediatrician for no reason, and the author had no opportunity to have skin-to-skin contact with him; she caught a glimpse of him only from afar. When he was brought back, clean and dressed, he was shown to her at hand level, but she could not touch him because her arms were still strapped down from the operation. She was ordered to give him a kiss, and he was brought close to her face, but then he was immediately taken away without her being able to say anything to him. The author requested that the baby be given to his father and was told: “Calm down, little girl, it’s all over.” The author could hear instructions on how to sew her up being given to the students. They finished without saying a word to her.

⁴ Basic Act No. 41/2002 of 14 November regulating patient autonomy and rights and obligations in the area of clinical information and documentation.

2.12 Over the next few hours, the author asked for the baby to be brought to her, but he was not, contrary to the recommendations of the Spanish Paediatric Association on care and assistance for healthy newborns.

2.13 In addition to being separated from his mother, the baby was bottle-fed, despite the parents' having stated that they wanted him to be breastfed. Bottle-feeding subsequently made it difficult to breastfeed him when, after three hours, he was finally returned to the author. Probably as a result of the bottle-feeding, the baby had difficulty latching onto the author's breast, forcing the parents to ask for formula milk.

2.14 Later, the author suffered from abdominal pain in the caesarean scar and lower abdomen and from urinary incontinence. She received treatment to stretch the scar, relax the diaphragm and reduce abdominal pressure.

2.15 The author also had to see her primary care physician about symptoms of anxiety related to her childbirth experience. In a report dated 7 June 2013 by the Andoain Mental Health Centre of the Basque Health Service, the author was diagnosed with post-partum post-traumatic stress disorder, anticipatory distress and anxiety, emotional instability and reactive depression, and was prescribed tranquillizers.

2.16 On 20 November 2014, the diagnosis of post-partum post-traumatic stress disorder was confirmed by a psychiatric specialist who serves as a professor at the University of Alcalá de Henares and a technical adviser to the Ombudsperson. This specialist confirmed that the disorder was the result of the way in which care had been provided to the author during the birth of her son and stated that it "could have been avoided through informed consent, which is related to the rights to moral integrity and to freedom, and is indicative of the fact that deprivation of personal autonomy can produce a psychological injury". The specialist further stated that "had the author been treated differently throughout childbirth, she certainly would not have exhibited such intense symptoms nor would she still be suffering now". The specialist thus established a direct causal relationship between the treatment received and the psychological injury.

2.17 On 16 July 2015, the specialist expanded her report to state that the symptoms exhibited by the author following childbirth "meet all the criteria for the diagnosis of post-traumatic stress disorder", that her case was an illustrative and paradigmatic example of what is observed by the World Health Organization (WHO) and experts in the context of post-partum trauma, and that, in addition to failing to provide adequate care and show respect during childbirth, the medical professionals had subsequently denied the severity and impact of the resulting symptoms.

Complaints filed by the author

2.18 On 9 July 2013, the author filed a claim against the Basque Health Service invoking the financial responsibility of the public administration for medical malpractice in the care that she received during labour. The author noted in particular: (a) the early and unnecessary induction of labour, "in breach of the protocol", without providing information to her or seeking her consent for the method of induction; (b) the performance of a caesarean section without providing information to her or seeking her consent; (c) the fact that the caesarean section was performed by students, supervised by a tutor, without the author's consent to serve for such purposes; (d) the author's unnecessary separation from her newborn; (e) bottle-feeding without the consent of the parents, who had stated that they wanted their child to be breastfed; and (f) the physical and psychological trauma that she experienced following childbirth, which violated her physical and moral integrity, her dignity and her personal and family privacy.

2.19 On 1 October 2013, the author brought before the administrative proceedings the report of a midwife who had assisted in the labour and who maintained that at no point was there a risk of loss of fetal well-being, that not enough time had elapsed to order a caesarean section, and that there were no consent forms for the induction of labour or the caesarean section.

2.20 In the absence of a response from the administration, and given that the respondent administration had missed, by a wide margin, the deadline for resolving the matter, the author submitted, on 25 March 2015, an application to Administrative Court No. 3 of Donostia-San Sebastián against the presumed dismissal of her claim invoking financial responsibility.

2.21 The author attached to her application the midwife's report (para. 2.19), the expert report of the psychiatric specialist (paras. 2.16–2.17) and the expert report of a specialist in gynaecology and obstetrics revealing malpractice in the care provided and stating that alternatives to the caesarean section had been available. The conclusions of this report were that the actions of the health personnel did not comply with *lex artis*, that the protocols had not been followed, that the decision to induce labour had been taken without first assessing the obstetric conditions of the cervix, that labour had been induced with oxytocin without prior cervical ripening with prostaglandins as indicated in all the protocols, that a hasty diagnosis of stalled labour had been made, in less time than that provided for in the protocols, and that, if the rules and protocols had been followed, the author would most likely have had a normal labour. There is clear scientific evidence that other actions should have been taken.

2.22 On 13 October 2015, the Court dismissed her application. In the judgment, the Court emphasized that the birth plan was only an expression of wishes and stated that, when a health-care service is provided on the basis of scientific and technical knowledge, any possible damage caused by it does not give rise to financial responsibility on the part of the administration. According to the Court, the induction was consistent with *lex artis*, and the caesarean section had been performed owing to stalled labour. The Court cited a judgment of the Administrative Chamber, dated 2 July 2010, according to which labour “constitutes a natural process in respect of which informed consent has no meaning, since the will of the patient can in no way alter the course of events”. Regarding the post-partum post-traumatic stress disorder, the Court gave credence only to the report of the administration's inspector, who is not a psychiatric specialist and did not examine the author, according to which the author's experience was the result of her own character, not the treatment received, and concluded that there was no evidence to support the author's interpretation, which was a matter of mere perception.

2.23 Given that this was a summary proceeding for an amount of less than €30,000, an ordinary appeal was not possible, as indicated in the judgment itself. On 30 November 2015, before the deadline of 1 December 2015, the author therefore submitted an application for amparo (protection of rights) to the Constitutional Court for violation of the constitutional rights to freedom, to physical and moral integrity and to personal and family privacy; this application was dismissed.

Context in the State party and characterization of the facts as “obstetric violence”

2.24 Recalling that context analysis is fundamental to treaty bodies' consideration of communications, and citing the views of the Committee on the case of *Pimentel v. Brazil*, in which the context of the health system in Brazil had been examined, leading to the conclusion that the poor medical care provided to the victim during childbirth was a systemic problem in Brazil, the author argues that, in the present

communication, it is particularly important to understand the context of obstetric violence in the State party.

2.25 The author thus maintains that, in the State party, according to testimonies by various women, such comments as “you enjoyed making this baby, now you have to grin and bear it” and “stop crying, it’s not that bad” are common during labour. Women are also subjected to unnecessary medical procedures, including the abuse of oxytocics, caesarean sections and episiotomies, to accelerate labour. In that connection, the Spanish office of Médecins du Monde has concluded that the numbers of caesarean sections and episiotomies exceed those recommended by WHO. The author also refers to the report of the Centre for the Monitoring of Obstetric Violence in Spain, according to which, during labour, 50 per cent of women are not informed of interventions performed on them, 65.8 per cent of birth plans are not respected, 55.7 per cent of women are not allowed to eat or drink and 74.7 per cent of women are not allowed to choose their position as the baby is being born.⁵

2.26 The author argues that it is telling that the State party itself has recognized that its childbirth services are particularly interventionist in comparison with its European neighbours and that this does not appear to be justified by better outcomes, such as lower perinatal mortality or morbidity rates. On the contrary, many of the European countries with the lowest perinatal and neonatal mortality rates are the same countries that have the lowest rates of obstetric interventions during labour, namely the Nordic countries. In addition, interventionism has no basis in the available scientific evidence.⁶

2.27 The author mentions that the non-governmental organization Médecins du Monde defines obstetric violence as actions and behaviours that dehumanize and diminish women during pregnancy, childbirth and the post-partum period, such as physical and verbal mistreatment, humiliation, lack of information and consent, the abuse of medicalization and the pathologization of natural processes, and that lead to loss of freedom, autonomy and the ability to freely make decisions concerning their body and sexuality. According to the Centre for the Monitoring of Obstetric Violence, such violence is the act of ignoring the authority and autonomy that women have over their sexuality, their bodies, their babies and their experiences of pregnancy and childbirth. It is also the act of ignoring the spontaneity, positions, rhythms and times required for labour to progress normally.

2.28 The author maintains that obstetric violence reflects underlying variables related to the appropriation of control over and responsibility for the process of labour by health personnel. The asymmetrical relationship between women and health professionals leads to an added inequality that results from the doctor-patient hierarchy, in which the professionals appropriate a position of knowledge and power through their actions, since they have the necessary social legitimacy to assert

⁵ Results of the surveys carried out by the Centre for the Monitoring of Obstetric Violence, available at <https://www.elpartoesnuestro.es/sites/default/files/public/OVO/informeovo2016.pdf>; and Cristina Medina Pradas and Paz Ferrer Ispizua, “Prevalence of obstetric violence in Spain”, infographic, 2017, available at <https://mamacapaz.com/wp-content/uploads/VO.pdf>.

⁶ Adela Recio Alcaide, “La atención al parto en España: cifras para reflexionar sobre un problema” (Care during childbirth in Spain: figures to reflect on a problem), *Dilemata*, year 7, No. 18 (2015), pp. 13–26.

themselves in that role.⁷ This reduces women's ability to take care of themselves and makes them dependent on a technical medical intervention.⁸

2.29 The author maintains that obstetric violence is a type of violence that can only be exercised against women and constitutes one of the most serious forms of discrimination. Discrimination is based on gender stereotypes, the purpose of which is to perpetuate stigmas related to women's bodies and women's traditional roles in society with regard to sexuality and reproduction.

2.30 The European Court of Human Rights has concluded that the right to respect for private and family life is violated when women cannot take health-related decisions autonomously during pregnancy, childbirth and the post-partum period,⁹ and has established that women have the fundamental right to choose the circumstances in which they give birth,¹⁰ that the separation of a baby from its mother after birth requires exceptional justification as it is a traumatic act,¹¹ and that certain acts and omissions of States in the field of health-care policy may engage States' responsibility on the grounds of inhuman or degrading treatment, because such acts and omissions cause feelings of insecurity, anguish, uncertainty and humiliation.¹²

2.31 The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has noted that obstetric violence results in physical and psychological suffering that can constitute ill-treatment.¹³

2.32 The author notes that obstetric violence was recognized as such in 2014 by WHO, which stated that "many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such 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". WHO highlighted the need for "greater action, dialogue, research and advocacy on this important public health and human rights issue".¹⁴ In addition, the Human Rights Council first used the term "obstetrical violence" in 2016, when it recommended that States ensure that penalties are incurred for gynaecological or obstetrical violence.¹⁵

Allegation

3.1 The author maintains that she has exhausted all domestic remedies available to seek redress for the obstetric violence that she suffered during labour.

3.2 The author maintains that her rights were violated under articles 2, 3, 5, and 12 of the Convention through: (a) the unnecessary induction of labour, which altered the natural process, without providing any information to her or allowing her to choose the method of induction; (b) the performance of a medically unnecessary caesarean

⁷ See Laura Belli, "La violencia obstétrica: otra forma de violación a los derechos humanos" (Obstetric violence: another form of human rights violation), *Revista Redbioética/UNESCO*, year 4, vol. 1, No. 7 (2013), pp. 25–32.

⁸ See Marbella Camaraco, "Patologizando lo natural, naturalizando lo patológico. Improntas de la praxis obstétrica" (Pathologizing the natural, naturalizing the pathological: Impressions from obstetric praxis), *Revista venezolana de estudios de la mujer*, vol. 14, No. 32 (2009).

⁹ See European Court of Human Rights, *Konovalova v. Russia*, Application No. 37873/04, Judgment of 9 October 2014.

¹⁰ See European Court of Human Rights, *Ternovszky v. Hungary*, Application No. 67545/09, Judgment of 14 December 2010.

¹¹ See European Court of Human Rights, *P., C. and S. v. the United Kingdom*, Application No. 56547/00, Judgment of 16 July 2002.

¹² See European Court of Human Rights, *P. and S. v. Poland*, Application No. 57375/08, Judgment of 30 October 2012.

¹³ See [A/HRC/31/57](#), para. 47.

¹⁴ See WHO, document WHO/RHR/14.23.

¹⁵ See [A/HRC/32/44](#), para. 106 (h).

section, without providing information to her about the risks and alternatives and without seeking her consent, despite the fact that it is major abdominal surgery that carries a risk of maternal death that is between two and four times higher than that of vaginal delivery and has worse neonatal outcomes; in an operating theatre that became a classroom where she was used as an example so that students could learn how to perform a caesarean, which gave rise to two issues, namely privacy and consent; and without the presence of her husband either during the surgery or in the hours that followed, contrary not only to the WHO recommendation that women should be accompanied by a person of their choosing during childbirth, but also to the recommendation of the Ministry of Health and Social Policy that women should be offered the opportunity to be accompanied by a person of their choosing, without restrictions, during labour and childbirth;¹⁶ (c) the physical consequences of the major abdominal surgery, which required rehabilitative physiotherapy treatment; (d) the separation, without medical justification, from her newborn baby, whom she was unable to hold when he was brought to her briefly, because her arms were still strapped down; (e) the disrespect for her autonomy regarding the feeding of her child; and (f) the psychological injury – namely, post-partum post-traumatic stress disorder – resulting from her experience in the hospital.

3.3 Regarding the violation of article 5 of the Convention, the author claims that she received such poor care because of the persistence of gender stereotypes related to women's lack of autonomy over decisions about their sexual health, maternity care and childbirth. The doctors' use of infantilizing terms such as "little girl" was related to biases or stereotyped views of women as being incapable of making their own decisions. In addition, stereotypes distorted the perception of the judge, who referred only to the hospital's report and accepted its assertions. The judge did not take into account the disregard of the protocols, the absence of documents related to informed consent or the reports provided by the author during the proceedings to prove malpractice, namely the midwife's report (para. 2.19) and the expert report of a specialist in gynaecology and obstetrics (para. 2.21). The judge also failed to take into account the reports related to the diagnosis of post-partum post-traumatic stress disorder that were submitted, namely the reports of the Andoain Mental Health Centre of the Basque Health Service (para. 2.15) and of the psychiatric specialist (paras. 2.16–2.17), and attributed the injuries and consequences suffered by the author to a matter of mere perception. Concerning the disregard of the testimony of the victims themselves, the author recalls that the Committee states, in paragraph 26 of its general recommendation No. 33, that stereotyping also affects the credibility given to women's voices, arguments and testimony as parties and witnesses. First the health personnel and then the judges assumed that women should follow doctors' orders because they are incapable of making their own decisions. The author claims that at no point did the authorities fully acknowledge the causes and effects of the phenomenon of obstetric violence as a form of gender-based violence that constitutes a grave violation of women's human rights. She claims that the authoritarian and paternalistic model of the doctor-patient relationship has resulted in the notion of women simply fulfilling a reproductive role and them having no say in how they give birth being generally accepted as "normal". The author recalls that, to properly implement article 5 of the Convention, States parties must take appropriate measures to modify stereotyped patterns of behaviour and eliminate structural discrimination.

3.4 Regarding the violation of articles 2 and 12 of the Convention, the author claims that the treatment that she received constitutes a violation of her rights to sexual and reproductive health and to receive safe, high-quality maternity care that is free from

¹⁶ Ministry of Health and Social Policy, *Maternidad Hospitalaria: Estándares y Recomendaciones* (Hospital maternity wards: standards and recommendations), available at <https://www.sanidad.gob.es/organizacion/sns/planCalidadSNS/docs/AHP.pdf>, p. 43.

discrimination and violence. She claims that the medical care, on the one hand, and the subsequent legal proceedings, on the other hand, demonstrate that the State party has not complied with its obligations to protect women from discrimination and violence during pregnancy, childbirth and the post-partum period. She recalls that, in line with article 2, States parties must ensure that State institutions abstain from engaging in acts of direct or indirect discrimination against women. She points out that this implies an obligation of result to abolish any practice that has the effect of generating discrimination, since allowing discriminatory attitudes based on gender stereotypes is a violation of the Convention.¹⁷

3.5 The author alleges that article 3 of the Convention was violated because she was not allowed to give birth in a manner consistent with respect for her human rights. She recalls that, since 1985, WHO has been urging Governments to promote obstetric care services that reflect critical attitudes towards technology and that respect the emotional, psychological and social aspects of birth, and indicates that the excessive and unjustified use of caesarean sections should be monitored by researching and publicizing their harmful effects on mother and child.¹⁸

3.6 The author requests individual reparation for the violations suffered and the preparation by the State party of studies and statistics to combat and raise awareness of obstetric violence, as a measure of non-repetition. The author also requests the Committee to draw up a general recommendation on obstetric violence, since it is a practice from which women are suffering worldwide.

State party's observations on admissibility and the merits

4.1 In its observations of 9 March 2020, the State party argues that the communication is inadmissible because the author is seeking a review of the assessment of the evidence made by the courts. According to the State party, the domestic courts have already conducted an exhaustive assessment of the evidence.

4.2 The State party also maintains that the communication is inadmissible because domestic remedies have not been exhausted, since the author did not submit a claim on the grounds of a violation of her fundamental rights but rather a claim invoking financial responsibility of €21,175 for malpractice on the part of the health administration, followed by an administrative appeal and an application for amparo.

4.3 In addition, the State party maintains that the Convention was not violated because the assessment of the evidence was not arbitrary, no manifest error was made and justice was not denied.

4.4 In particular, the State party stresses that the medical decisions were taken not only for the author's health, but also for that of the newborn, an element that is missing from the written submissions of the author, who only expresses her wishes and preferences. The State party points out that informed consent is sought only for scheduled caesarean sections and reiterates the judgment of the Administrative Chamber of 2 July 2010, in which it is stated that childbirth "constitutes a natural process in respect of which informed consent has no meaning, since the will of the patient can in no way alter the course of events". The State party affirms that there is no such thing as "à la carte" childbirth and that the decision on the means of delivery lies solely and exclusively with the medical professional. It notes that the caesarean was performed 31 hours after the author's waters had broken and that it had been carried out because her labour had stalled at 7 centimetres of dilation. The State party

¹⁷ The author cites general recommendations No. 27 and No. 28.

¹⁸ WHO, "Appropriate technology for birth", *The Lancet*, vol. 326, issue 8452 (24 August 1985).

also points out that the caesarean rate at that particular hospital is 14.7 per cent, well below the national average of 25 per cent.

4.5 Regarding the claim of post-traumatic stress disorder, the State party argues that “there is no evidence to support this interpretation beyond the author’s mere perception”.

4.6 The State also indicates that, although the author claims to have stated in her birth plan that she did not want drugs to be administered to induce or accelerate labour, epidural anaesthesia was administered at her request.

4.7 The State party also argues that the operation was not carried out by students, noting that the list of persons involved in the operation shows clearly that the procedure was performed by medical residents undergoing training, together with specialist gynaecologists.

4.8 More generally, the State party also argues that the communication is not, in itself, an individual communication. It claims that the author should have submitted a report in the context of a periodic review, since her aims are for the State party to develop studies and statistics on obstetric violence and for the Committee to draft a general recommendation on the issue.

Author’s comments on the State party’s observations on admissibility and the merits

5.1 On 8 May 2020, the author stated that she was not seeking a review of the domestic judgments or to have the Committee act as an appellate or cassation court or for a retrial to be ordered. She notes that the purpose of the communication is for the Committee, once it has analysed all the facts and evidence presented, to determine whether or not the State party, through its health, administrative and judicial bodies, complied with the commitments it made upon ratification of the Convention and the Optional Protocol and to recommend transformative reparations to guarantee non-repetition of similar situations in the future.

5.2 With regard to the allegation that the procedure selected for the purpose of upholding her rights is inappropriate, the author recalls that the purpose of the requirement that domestic remedies be exhausted is to ensure that States parties have the opportunity to remedy a violation. It does not mean that victims must exhaust all available remedies, but rather that they must raise the issue through one of the alternative judicial remedies that are available under the domestic legal system. If more than one possible effective remedy is available, victims may select the one they consider most appropriate. She argues that she pursued legal and legitimate ways of exhausting domestic remedies, namely by submitting a claim invoking financial responsibility, lodging an appeal before the administrative courts and applying for amparo, in which she expressly invoked the violation of the rights to physical and psychological integrity, to personal and family privacy and to receive information and decide freely, having made the argument as to why the acts she suffered constitute discrimination based on gender and sex.

5.3 With regard to the merits of the communication, the author notes that the State party relies solely on a report from the Basque Health Service, that is, the administration that is the respondent at the domestic level. The State party relies on the same gender stereotypes, dismissing all of her allegations without understanding that her experience should be accorded the same importance as the medical assessments. She argues that the State party allowed gender stereotypes and discrimination against women to be perpetuated, both in the clinical process of labour and during the judicial proceedings.

5.4 The author also notes that the State party's observations, which refer to the ruling of the judge who heard her case (paras. 2.22 and 4.3), fail to accurately cite the administrative decision that they intend to use to argue that consent was supposedly not necessary. Although the judgment does indeed state firstly that "the process of labour, when it is imminent and inevitable, constitutes a natural process in respect of which informed consent has no meaning, since the will of the patient can in no way alter the course of events", it goes on to say something that is not cited by the judge or by the State party: "It is a different matter if extraordinary methods, such as a caesarean section, are used to facilitate labour, in which case the patient's informed consent must be obtained, except in the event of an emergency, but this is not what occurred in this case". The author therefore argues that the Supreme Court is saying the exact opposite of the claim made by the judge who heard her case, and by the State party, which merely repeated that claim. It is saying that consent is required when an extraordinary method of delivery, such as a caesarean section, is performed, except in the event of an emergency, which was not what occurred in this case. The author argues that it is therefore necessary for the Committee to confirm the full enforceability of informed consent in the area of women's sexual and reproductive health, in accordance with its own general recommendation No. 24.

5.5 Again, the State party's response simply refers to the ruling of the judge on post-traumatic stress disorder, which is supposedly a matter of "mere perception" (para. 2.22), while ignoring the objective diagnoses made both by a psychiatrist from the Basque Health Service that treated the patient and by a psychiatric specialist.

5.6 The author also notes that the State's argument that she herself requested an epidural injection is biased. Consent to induce or accelerate labour, which she expressly refused, is not interchangeable with consent to be given an epidural. Medication used to induce or accelerate labour causes so much pain that the use of an epidural to relieve pain during labour is almost inevitable. The State party cannot blame her for resorting to methods of pain relief when her pain levels had increased precisely as a result of the administration of drugs to accelerate labour, which she had refused; moreover, she had expressly declined drugs to accelerate labour, not drugs to relieve pain.

5.7 The author emphasizes the context of the present communication and requests the Committee to initiate the inquiry procedure on the situation of obstetric violence in Spain. She reiterates that it is crucial to make transformative reparations that offer a guarantee of non-repetition.

Third-party intervention

6. On 21 May 2020, the Centre for the Monitoring of Obstetric Violence stated that the present communication was paradigmatic of the serious public health problem that obstetric violence poses in the State party. A study revealed that consent is not sought in 45.8 per cent of cases, that unnecessary procedures are performed in 38 per cent of cases and that there is excessive interventionism in perinatal care: in spontaneous vaginal deliveries, synthetic oxytocin, a high-risk medication, is administered in 53.3 per cent of cases, when the recommended standard is between 5 and 10 per cent; induced labours account for 19.4 per cent of the total (when the recommended standard is less than 10 per cent); the Kristeller manoeuvre is still used in 26 per cent of deliveries (when the recommended standard is 0 per cent); the caesarean section rate is 22 per cent (when the recommended standard is less than 15

per cent); and mother-infant separation still occurs in 50 per cent of births, leading to difficulties in bonding and breastfeeding.¹⁹

7. On 25 May 2020, María Fuentes Caballero from the Artemisa Health Centre in Cádiz reported that, on a daily basis, women were being forced into non-physiological birthing positions, given treatment without being provided with sufficient information, and separated from their babies unnecessarily.

8.1 On 2 June 2020, students from the Study Centre for Human Rights and Humanitarian Law of the Panthéon-Assas University in Paris, France, recalled that the Special Rapporteur on violence against women, its causes and consequences, uses the term “obstetric violence” to refer to violence suffered by women during labour.²⁰ The same term is also used by the Committee on Equality and Non-Discrimination of the Council of Europe in its report dated 16 September 2019 on obstetric and gynaecological violence. The submitter argues that obstetric violence is a reflection of entrenched gender discrimination in the health sector, aggravated by the fact that men are overrepresented in the field of obstetrics and gynaecology. Despite its importance, there is a real taboo surrounding childbirth, which prevents victims from testifying and seeking redress, and in turn increases impunity and harm to victims.

8.2 The submitter argues that, in order to prevent obstetric violence, States have obligations relating to the treatment of women in delivery rooms, such as the obligation to eradicate customs and practices that perpetuate the notion of women’s inferiority through awareness-raising programmes for medical services and the obligation to guarantee women’s full informed consent. The submitter recalls that the Pan American Health Organization, in its publication *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors*, states that the patient has the right to decline medical treatment, regardless of a doctor’s opinion.

8.3 The submitter also argues that States have obligations related to judicial and administrative remedy for obstetric violence, including by providing effective remedies for victims of obstetric violence; guaranteeing justice free of stereotypes, which does not happen when administrative and judicial authorities assume, for example, that it is up to the doctor to decide whether or not to perform an episiotomy or that psychological harm is a matter of “mere perception”; criminalizing obstetric violence; and introducing legal penalties in their domestic law.

9. On 10 June 2020, the Centre for the Monitoring of Obstetric Violence in Chile reported that the elements set out in the present communication are common in Chile: women are infantilized; they are subjected to premature artificial induction of labour, resulting in unnecessary caesarean sections; their physical and psychological needs are ignored;

10. On 24 June 2020, the Information Group on Reproductive Choice in Mexico stated that it defines obstetric violence as a specific form of violence against pregnant women that is caused by an act or omission during pregnancy, childbirth or the post-partum period, within public and private health services, leading to physical and/or psychological harm to pregnant women. Examples of such harm may include lack of access to reproductive health services, cruel, inhuman or degrading treatment and the abuse of medicalization, undermining women’s capacity to make free and informed decisions about these reproductive processes. Obstetric violence can be physical, through invasive practices, such as caesarean sections without medical indication,

¹⁹ Susana Iglesias Casás, Marta Conde, Sofia González and Maria Esther Parada. “Violencia obstétrica en España, ¿realidad o mito? 17.000 mujeres opinan” (Obstetric violence in Spain: myth or reality?).

²⁰ 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](#).

unjustified administration of medication, delayed emergency health care or disregard for the natural stages of labour. Obstetric violence can also be psychological, such as discrimination, use of offensive, humiliating or sarcastic language and failure to provide timely information about the reproductive process.

11. On 30 June 2020, the Network for the Humanization of Labour and Birth in Brazil recalled that, according to WHO, the increasing medicalization of childbirth processes tends to undermine women's own capability to give birth and has a negative impact on their experience of childbirth.²¹

Comments and observations on the third-party submissions

12. On 30 July 2020, the author welcomed the interest in her communication, which was described as paradigmatic of an issue of international concern. The author adheres to the proposed definition.

13. On 14 August 2020, the State party indicated that it adhered to its observations.

Issues and proceedings before the Committee

Consideration of admissibility

14.1 In accordance with rule 64 of its rules of procedure, the Committee must decide whether the communication is admissible under the Optional Protocol.

14.2 In accordance with article 4.2 (a) of the Optional Protocol, the Committee is satisfied that the same matter has not been and is not being examined under another procedure of international investigation or settlement.

14.3 The Committee takes note of the State party's argument that the communication is inadmissible because domestic remedies have not been exhausted, since the author did not submit a claim on the grounds of violation of her fundamental rights but rather a claim invoking financial responsibility, followed by an administrative appeal and an application for amparo. The Committee also takes note of the author's claim that the remedy she pursued is a legitimate legal means of exhausting domestic remedies. In this connection, the Committee recalls that the authors of an individual communication are not obliged to exhaust all available remedies but must give the State party the opportunity, through a relevant chosen mechanism, to remedy the matter within its jurisdiction.²² The Committee notes that the author raised before the domestic courts all the issues before it regarding the alleged obstetric violence she suffered (namely, early induction of labour without providing information or seeking consent, performance of a caesarean section without her consent and performed by medical residents undergoing training and supervised by tutors, separation from her child, bottle-feeding and physical and psychological trauma, which she alleges violated her physical and moral integrity, her dignity and her personal and family privacy) and that she has exhausted the administrative remedies; she subsequently filed a remedy of amparo before the Constitutional Court for violation of her fundamental rights. Accordingly, the Committee considers that the author has exhausted a remedy that appeared relevant to satisfy her claims before the Committee and concludes that domestic remedies have been exhausted for the purposes of article 4 (1) of the Optional Protocol.

14.4 The Committee notes the State party's argument that the communication is inadmissible because the author is seeking a review of the domestic courts' assessment of the facts and evidence. The Committee also notes the author's claim

²¹ See WHO recommendations: Intrapartum care for a positive childbirth experience. Washington, D.C.: Pan American Health Organization; 2019.

²² See, inter alia, the Committee's views in *S.F.M. v. Spain* (CEDAW/C/75/D/138/2018), para. 6.3.

that she is not seeking a review of the evidence or that a retrial be ordered, but that she presented all the facts and evidence to argue that the legal proceedings in her case were imbued with gender stereotypes regarding childbirth, which distorted the judge's discernment. The Committee further notes the author's claim that the judicial authorities did not take into account the various pieces of expert evidence she provided throughout the proceedings. The Committee considers that these allegations, which relate to the denial of justice and gender-based discrimination resulting from stereotypes, are directly related to the merits of the communication and therefore concludes that it has the power to examine the present communication and thus to determine whether there was any irregularity in the judicial process in relation to the obstetric violence alleged by the author.

14.5 The Committee considers that the allegations under articles 2, 3, 5 and 12 of the Convention have been sufficiently substantiated for the purposes of admissibility, and therefore declares the communication admissible and proceeds to examine it on the merits.

Consideration of the merits

15.1 The Committee has considered the present communication in the light of all the information placed at its disposal by the author and the State party, in accordance with the provisions of article 7 (1) of the Optional Protocol.

15.2 The Committee notes that the author claims that having her labour induced unnecessarily, then having a caesarean section performed without it being medically indicated and by students supervised by tutors, without the presence of her husband and all without her prior consent, as well as the unjustified separation from her newborn baby, the failure to respect her autonomy with regard to the manner of feeding of her child and, ultimately, the post-partum post-traumatic stress disorder she suffered, were the result of structural discrimination based on gender stereotypes regarding childbirth. The author maintains that these stereotypes were perpetuated in the administrative and judicial proceedings. The judge did not take into account the disregard of the protocols, the reports provided by the author to prove malpractice or the reports submitted concerning the diagnosis of post-partum post-traumatic stress disorder, but rather described the injuries suffered by the author as a mere matter of perception. The Committee notes that the author claims that her rights to sexual and reproductive health and to access to safe and high-quality maternity services free from discrimination and violence were violated, in violation of articles 2, 3, 5 and 12 of the Convention. The Committee also notes that, according to the State party, the caesarean was performed once the labour was considered to have stalled, and that there is no such thing as "à la carte" labour, the decision on the means of delivery resting exclusively with the medical professional. The Committee also notes that, according to the State party, there is no evidence to support the existence of the post-traumatic stress disorder alleged by the author, beyond her mere perception.

15.3 The Committee recalls that, according to its general recommendation No. 24 (1999) on women and health, quality health-care services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. The general recommendation also states that women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives.

15.4 The Committee also considers it appropriate to examine the phenomenon described as obstetric violence. In this regard, it notes that the Special Rapporteur on violence against women, its causes and consequences, defines "obstetric violence" as

the violence against women experienced during facility-based childbirth and affirms that this form of violence has been shown to be widespread and systematic in nature or engrained in the health system.²³ According to the Special Rapporteur, it is part of a continuum of the violations that occur in the wider context of structural inequality, discrimination and patriarchy, and also the result of a lack of proper education and training, as well as lack of respect for women's equal status and human rights.²⁴ Particularly relevant to the present communication are the Rapporteur's assertions that a caesarean section practised without the woman's consent²⁵ and the use of trainee medical staff to carry out gynaecological examinations are acts that may amount to obstetric violence.²⁶ Also of particular relevance is her assertion that informed consent for medical treatment related to reproductive health services and childbirth is a fundamental human right. Women have the right to receive full information about recommended treatments so that they can make well-considered and informed decisions. Health professionals therefore have an obligation to obtain informed consent, even though it can be challenging and time-consuming.²⁷ Lastly, also relevant to the present communication is the recommendation, for the prevention of obstetric violence, to guarantee women's right to a birth companion of their choice.²⁸

15.5 The Committee recalls that, in its concluding observations, it has taken note of the rapid increase in the rate of caesarean sections performed without any medical indication or consent, as well as the separation of newborns from their mothers with no medical justification and the patronizing attitudes of doctors,²⁹ and has recommended that States parties adopt "legal and policy measures to protect pregnant women during childbirth, penalize obstetric violence, strengthen capacity-building programmes for medical practitioners and ensure regular monitoring of the treatment of patients in health-care centres and hospitals".³⁰ In its examination of individual communications, the Committee has also ruled on facts similar to those in the present case, related to the same context in the same State party, finding violations of articles 2 (b), (c), (d) and (f), 3, 5 and 12 of the Convention.³¹ It previously attributed State responsibility for the preventable maternal death of a woman as a result of obstetric complications after being denied high-quality maternity care,³² as well as for a case of forced sterilization.³³

15.6 The Committee recalls that it is generally for the authorities of States parties to evaluate the facts and evidence and the application of national law in a particular case, unless it can be established that the evaluation was conducted in a manner that was biased, based on gender stereotypes that constitute discrimination against women or clearly arbitrary or that amounted to a denial of justice.³⁴ In the present communication, the Committee must assess the State party's compliance with its obligation to exercise due diligence in the administrative and judicial proceedings initiated because of the acts that are the subject of the author's complaint and with a view to ending gender stereotypes. In this regard, the Committee notes that, according to the State party, the domestic courts carried out a thorough assessment of the

²³ [A/74/137](#), paras. 4, 12 and 15.

²⁴ *Ibid.*, para. 9.

²⁵ *Ibid.*, para. 24.

²⁶ *Ibid.*, para. 26.

²⁷ *Ibid.*, para. 32.

²⁸ *Ibid.*, para. 81.

²⁹ See [CEDAW/C/CZE/CO/5](#), paras. 36 and 37, and [CEDAW/C/CZE/CO/6](#), paras. 30 and 31.

³⁰ [CEDAW/C/CRI/CO/7](#), para. 31.

³¹ [CEDAW/C/75/D/138/2018](#).

³² [CEDAW/C/49/D/17/2008](#).

³³ [CEDAW/C/36/D/4/2004](#).

³⁴ [CEDAW/C/70/D/76/2014](#), para. 7.7.

evidence. The Committee also notes that, according to the author, in spite of the various elements of evidence and reports that demonstrated the cause-and-effect relationship between the health service's actions and the harmful outcome, the administrative and judicial authorities gave credence only to the hospital reports and made assumptions based on stereotypes. According to the gynaecological and obstetric clinical reports provided by the author, both to the domestic courts and to the Committee, the medical personnel did not comply with *lex artis*, namely, the protocols were not followed, not enough time had elapsed before performing a caesarean section, a diagnosis of stalled labour had been made in haste, there were alternatives to the caesarean section and there are no consent forms for the induction of labour or the caesarean section as required by the Patient Autonomy Act. As the reports make very clear, had the applicable standards and protocols been followed, the author was very likely to have experienced a normal birth (paras. 2.19 and 2.21). Furthermore, according to the psychiatric and psychological reports provided by the author, both to the domestic courts and to the Committee, the author's symptoms following childbirth meet all the criteria for the diagnosis of post-traumatic stress disorder, and her case was described by a psychiatric specialist as illustrative and paradigmatic of what is observed by WHO, the principal United Nations organization in the field of health (paras. 2.15 to 2.17). However, the Committee notes that in the present case, the national authorities did not carry out an exhaustive analysis of these elements of the evidence submitted by the author. In this regard, the Committee notes that the judgment rejecting the author's claim did not give weight to these elements of the evidence in the face of the medical report provided by the hospital, which states that the medical professional was the person who must verify whether the prerequisites for performing a caesarean section had been met, and that the labour had stalled, and relied solely on the latter to conclude that the induction and subsequent caesarean section were carried out in accordance with *lex artis*. In this regard, the Committee notes that, according to the judge, in a medical liability proceeding, the medical reports in the file, those submitted by the parties with their complaint or response, and also those requested by the court, which enjoy greater guarantees because they are presumed to be independent and objective in comparison to the reports submitted by the parties, must all be evaluated. In the present case, however, the same judge did not request the preparation of any expert report as part of the court proceedings. The Committee also notes that, with regard to post-partum post-traumatic stress disorder, the judgment concluded that there was no evidence to support the author's interpretation, without giving credence to the report of a psychiatric specialist who established a direct causal link between the author's treatment and the psychological injury. That report stated that the diagnosis of post-partum post-traumatic stress disorder was the result of the way in which the author had been treated, that it "could have been avoided through informed consent, which is related to the rights to moral integrity and to freedom, indicating that deprivation of personal autonomy can produce a psychological injury", and that "had the author been treated differently throughout childbirth, she certainly would not have exhibited such intense symptoms nor would she still be suffering now". The judgment's conclusion was reached on the grounds that the report "establishes a questionable single causal link", thus giving credence only to the report of the administration's inspector, who did not examine the author, and who concluded that the author's experience was the result of her own character traits.

15.7 The Committee considers that the facts of the present case constitute obstetric violence – in particular, the early induction of labour via oxytocin, only 14 hours after the author's waters had broken, without providing her with information or requesting her consent, the multiple digital vaginal examinations performed, not allowing her to eat, the infantilization, the performance of a caesarean section by medical residents without the author's consent, without allowing her husband to accompany her and

while her arms were tied down, and the separation from her baby, which made skin-to-skin contact impossible, none of which has been contested by the State party, together with the imposition of bottle-feeding contrary to the parents' wishes and the physical and psychological consequences of the events for the author.

15.8 In this context, the Committee recalls that, under articles 2 (f) and 5, States parties have the obligation to take all appropriate measures to modify or abolish not only existing laws and regulations but also customs and practices that constitute discrimination against women.³⁵ The Committee considers that stereotyping affects the right of women to be protected against gender-based violence, in this case obstetric violence, and that the authorities responsible for analysing responsibility for such acts should exercise particular caution in order not to reproduce stereotypes. The Committee notes that, in the present case, the State party's administrative and judicial authorities applied stereotypical and therefore discriminatory notions, for example by assuming that it is the doctor who decides whether or not to perform a caesarean section without duly analysing the evidence and reports submitted by the author which point to there having been alternative courses of action to a caesarean section, or by assuming that the psychological injuries suffered by the author were a matter of mere perception.

15.9 Consequently, acting under article 7 (3) of the Optional Protocol, the Committee is of the view that the facts before it reveal a violation of the rights of the author under articles 2 (b), (c), (d) and (f), 3, 5 and 12 of the Convention.

16. In the light of the above conclusions, the Committee makes the following recommendations to the State party:

(a) Concerning the author: provide her with the appropriate reparation, including adequate financial compensation for the damage that she suffered to her physical and psychological health;

(b) General:

(i) Ensure women's rights to safe motherhood and access to appropriate obstetric services, in accordance with general recommendation No. 24 (1999) on women and health; and, in particular, provide women with adequate information at each stage of childbirth and establish a requirement for their free, prior and informed consent to be obtained for any invasive treatment performed during childbirth, thereby respecting their autonomy and their capacity to make informed decisions about their reproductive health;

(ii) Conduct research into obstetric violence in the State party in order to shed light on the situation and thus provide guidance for public policies to combat such violence;

(iii) Provide obstetricians and other health workers with adequate professional training on women's reproductive health rights;

(iv) Ensure access to effective remedies in cases in which women's reproductive health rights have been violated, including in cases of obstetric violence, and provide specialized training to judicial and law enforcement personnel.

(v) Establish, publicize and implement a Patients' Bill of Rights.

17. In accordance with article 7 (4) of the Optional Protocol, the State party shall give due consideration to the views of the Committee, together with its recommendations, and shall submit to the Committee, within six months, a written

³⁵ See *González Carreño v. Spain* (CEDAW/C/58/D/47/2012), para. 9.7.

response, including information on any action taken in the light of the views and recommendations of the Committee. The State party is also requested to publish the Committee's views and recommendations and to have them widely disseminated in order to reach all sectors of society.
