Degree in Law

Final Thesis

OBSTETRIC VIOLENCE AS A FORM OF VIOLENCE AGAINST WOMEN, FROM A SOCIAL AND LEGAL PERSPECTIVE.

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Las mujeres deben mirarse como dueñas
de su persona y con plenos poderes sobre ella.
— Stendhal.

Abstract.

The recognition of the term obstetric violence itself has been a discussion point for decades, before the term was even legally recognized. Overlooking and dismissing it reflects deeper rooted issues, which go to show, among other things, systemic disregard towards women's rights, promotion of an impunity culture and the difficulty to take judicial or extrajudicial measures. This paper aims to offer a better understanding of obstetric violence, placing it within the context of gender-based violence against women. With the particular case study as its focal point, the paper intends to examine the dynamics of obstetric violence, its manifestations and the implications on women's rights. A key component is the analysis of informed consent in the context of obstetric care, highlighting the consequences of restricting the ability of women's informed decision making. Moreover, the study sets its sight on laying out the existing Spanish (and international) legal framework, providing an analysis and evaluation of the legal protections offered.

Key words: obstetric violence, violence against women, pregnancy, childbirth, postpartum, informed consent.

Resumen.

El reconocimiento del término violencia obstétrica en sí mismo ha sido un punto de debate desde hace décadas, incluso antes de que fuera legalmente reconocido. Pasarlo por alto refleja problemas profundamente arraigados, que demuestran, entre otras cosas, el desprecio sistemático con respecto a los derechos de las mujeres, la promoción de una cultura de impunidad y la dificultad para tomar medidas judiciales o extrajudiciales. Este trabajo tiene como objetivo ofrecer una mejor comprensión de la violencia obstétrica, ubicándola en el contexto de la violencia de género. Teniendo como punto focal el estudio del caso particular, el trabajo pretende examinar las dinámicas de la violencia obstétrica, sus manifestaciones y las implicaciones para los derechos de las mujeres. Un componente clave es el análisis del consentimiento informado en el contexto de la atención obstétrica, destacando las consecuencias de restringir la capacidad de las mujeres para tomar decisiones informadas. Además, el estudio se centra en trazar el marco legal español (e internacional) existente, proporcionando un análisis y evaluación de las protecciones legales ofrecidas.

Palabras clave: violencia obstétrica, violencia de género, embarazo, parto, postparto, consentimiento informado.

CONTENT INDEX.

1. INTRODUCTION.

1.1. Rationale for the choice of the case.

The experience of pregnancy and childbirth is one that's supposed to be a specially joyful and positive one, which generally takes place in hospital birthing rooms, a place heavily associated with hopeful new beginnings. These birthing rooms, and hospitals in general, are meant to be a safe space in which mothers, accompanied by medical staff, bring their newborn babies to the world, a deeply transformative event in both of their lives.

However, this is unfortunately not the reality for all women who give birth, many of which are subjected to obstetric violence. It is a common misconception to view this violence simply as bad luck that some women experience at the hands of a couple of healthcare professionals when in reality, obstetric violence is one of the most under-recognized forms of violence against women, that inflicts physical and psychological pain and, in most cases, lifelong trauma, by disregarding their bodily autonomy and rights.

This paper is built upon the study of a particular case, Nahia Alkorta's, who suffered obstetric violence during her first birth at the hands of the public hospital of Donostia. In a summarized way, the case deals with the multiple interventions that were performed on her without her consent, without providing the necessary information regarding the interventions, all while treating her in a degrading and infantilizing way. Consequently, this meant a traumatic birth experience, with very painful physical and psychological effects.

The case was presented by lawyer Itziar Eizmendi in the Legal Clinic for Social Justice (Clínica Jurídica por la Justicia Social; hereafter, CJJS or the Clinic) at the University of the Basque Country (UPV/EHU), and I knew right away this was the case I wanted my paper to delve on.

One of the main reasons I chose this particular case was that, while it was being presented, I realized that, while I had heard of bad experiences during pregnancy and

mainly childbirth of many women around me, be it family, friends or even acquaintances, I had never identified it as a form of – gender-based – violence. At first, I supposed it could be an exceptional case in which medical malpractice was taken to extreme conditions, but upon hearing the full case, I was proven wrong. Nahia's case is not only not just medical malpractice, but also, one of the many cases in which women suffer violence in the context of obstetrics.

There is a sentiment, very similar to the one saying that "the end justifies the means" in these situations, in which people tend to say "if the baby is okay, it was worth it", as if all that the mother goes through is justified as long as the baby comes out healthy. This just goes to show how we, as a society, have normalized all the abuse and neglect that mothers go through during not only pregnancy and childbirth, but also postpartum, and have internalized that a completely positive experience is unrealistic and almost impossible to achieve.

Another reason for choosing this case was that regardless of my knowledge of many women's negative experiences, I had never heard the term obstetric violence before and, to my surprise, neither did most of these women. It is very difficult for women to try and fight against obstetric violence, when they are not aware that the mistreatment they face constitutes a form of violence. A violence that should've been avoided.

Naturally, one of the reasons the term is not particularly popular comes as a result of the pushback the medical community – and arguably, the legislative power – has exerted in terms of the recognition of the term in a general context, as well as in the legal or medical context. This pushback, its reasons and consequences will be analyzed later on in this paper.

Another reason was concerning the legal aspect of obstetric violence. Following up on what I stated beforehand about the term not being recognized, it left me to wonder how could a person who suffered obstetric violence denounce it, if it's not even recognized by the State. Upon research done after hearing the presentation of the case, I understood that under the current spanish legal legislation, it is extremely difficult to not

only take legal action, as there is no specific law to back the legal claim on, but also be justly compensated.

It was at the CJJS, and because of all the reasons previously listed, that I grasped the importance of addressing the issue of obstetric violence on a deeper level and bringing awareness to it.

1.2. Hypotheses and objectives.

In this paper, there are mainly two hypotheses proposed:

1. On the one hand, obstetric violence is made invisible and more often than not implies the – normalized – violation of the human rights of the women who suffer it, through the different harmful practices that are carried out.
2. On the other hand, current state regulations in Spain are not sufficient when it comes to addressing and preventing obstetric violence, and hence are discriminatory against women based on gender. Among other things, the violation of the right to informed consent stands out.

Taking into account the hypotheses proposed, the main objective of this work is to explore and shed light on the reality of obstetric violence, based on Nahia's experience, from which it is intended to make a social and legal study of obstetric violence and the existing norms and regulations – both Spanish and international – in relation to this.

Three other more specific objectives arise from this first objective:

1. In the first place, to examine the origin, manifestations and consequences of obstetric violence.
2. Secondly, to analyze how obstetric violence constitutes a manifestation of violence against women.
3. Third, to study the importance of informed consent in the obstetric context.

4. Fourth, to show the potential limitations – in terms of recognition, prevention and compensation – and legal gaps that the current international legislation entails.
5. Lastly, to make proposals to better understand, approach and deal with obstetric violence.

1.3. Methodology.

The CJJS proposes a development and methodology for the Degree's Final Thesis – and also, Master's Final Thesis – that is different from that which would be carried out normally. Far from opting for a strictly legal development, the Clinic opts for a perspective that, starting from the analysis of a specific case, promotes critical theoretical analysis, establishing a case of discrimination as the focus of the work.

By presenting the different cases in which people from different backgrounds affected in different ways by social injustice are protagonists, and subsequently observing the particular case chosen, the Clinic gives its students the opportunity to reflect on the different troubles that some member groups of society have to go through, the discrimination that they have to face, and the response that the state has for these situations, through the questioning of the law as an instrument that, allegedly, is fair and must fight to combat these unfair and discriminatory situations.

In this case, the first step aimed at carrying out this work was one of the seminars organized by the Clinic, which took place in January 2024, presented by the lawyer Itziar Eizmendi, who had presented the case in November of the previous year, and Nerea Azkona, both with great expertise and experience in the field of obstetric violence. Attending this seminar was an important advance that allowed me to inform myself and understand in greater depth the origin of this violence and everything that it entails, framing it in the context of violence against women.

Secondly, I conducted the interview with Nahia Alkorta, through the platform "Zoom" in March 2024. It was Nahia who proposed that the interview be carried out online since she had a busy schedule and this would mean greater ease and comfort for her when setting a specific date. The interview was carried out with the intention, on the

one hand, of listening to her experience through her own words, and on the other hand, of being able to deepen and understand her experience and opinions by asking a series of questions, which followed a script that I had prepared prior to the interview, following the suggestions and recommendations of Aldaz (2016), included in this work as Annex I.

Thirdly, for a greater understanding and analysis of the reality of women who suffer at the hands of obstetric violence, I carried out a bibliographical reading of books, articles and reports specialized on the subject, as well as the applicable state and international regulations that have an impact on these women, especially in terms of the ways they have to report this violence, and how the legislative and judicial bodies respond to it.

Lastly, along with the conclusions, I included a series of proposals, legal and sociopolitical, that I thought could help understand the issue at hand, in hopes of making knowledge and information accessible for everyone, choosing more mindful and correct ways of approaching obstetric care in order to prevent obstetric violence, and making the legal framework in this regard more effective and efficient.

2. CASE BACKGROUND: NAHIA'S EXPERIENCE.

In this section, Nahia Alkorta's experience will be put into words, according to the interview I conducted, her published book "Mi parto robado" (2023) and other materials regarding her case, such as the document emanating from the Committee on the Elimination of Discrimination against Women – hereafter, the Committee –.

2.1. Pregnancy.

Nahia's pregnancy was planned, calm and yet intense. She got pregnant with her first child when she was 25 years old, and was excitedly enjoying the process, and all that it entailed. She felt strong, and while she felt normal pregnancy symptoms, she was happy and wanted to remember the whole process (Alkorta, 2023).

When asked about the information she received concerning the birth of her baby, she talks about how much she informed herself. She attended childbirth preparation classes, did research on the birthing process, specifically less medicalized ones, as that was the kind of birth she wanted, and when she found information in Basque in this regard to be very little, she created an information website.

She also wrote a birth plan by recommendation of her midwife, who upon hearing Nahia wanted a physiological birth, recommended she write and send a birth plan to the hospital's Patient Care Service.

When she first started developing her birth plan, she started out with a long one, but realized that in order for it to be read, she had to make a shorter version. In it, she explains she prefers for the birth to be as natural as possible, to be informed and asked permission and consent to perform procedures and for there to be as least medical staff as possible. Her birth plan's English translation is included as Annex II.

When it came to her birth, she had an open mind, and while she had her preferences, she was not totally set on a certain type of birth.

2.2. Childbirth.

When Nahia's waters broke, she, along her partner, headed for the hospital, at around eight in the morning, where upon her arrival, a first digital vaginal examination was performed to check whether her sac "really was broken" (CEDAW, 2022, p. 2) and while this first procedure did not bother Nahia, it was here when she realized that there would be many things out of her control.

Afterwards, a gynecologist informed Nahia that if twenty-four hours passed and the labor process had not yet started, labor would have to be induced as there would be risk of infection (Alkorta, 2023).

However, later on that same day, at around four in the afternoon, a midwife enters the room Nahia's at, which happens to be the last one available, and asks her and her partner to get out and head for the delivery room, as they were going to induce labor

right then. Nahia, confused, tells the midwife about what the gynecologist had told her earlier about the twenty-four hour waiting period, and in response, the midwife tells her that they "do not induce at four in the morning" (ibid., p. 19).

After a little while and against her wishes, Nahia found herself in a different space, where she was understandably confused and scared, as despite her attempts to be informed, she was denied information, and later on would be denied food and water.

In the coming hours, many more digital vaginal examinations were performed, one of which was made by a trainee student, despite her request of having as little staff as possible, causing Nahia a lot of pain and discomfort.

During one of the digital examinations, Nahia asked a midwife that she assessed her progress and dilation, and even when she expressed to her that she was 7 centimeters dilated and the baby had moved further down, the group of gynecologist had already decided they would be performing a cesarean section, as the labor was allegedly stalled and they baby was suffering (ibid., pp. 27-29).

Upon hearing the gynecologists' claims, Nahia requested that the fetal scalp pH testing be done to her baby, also known as the "suffering test" and performed to assess if the child is suffering, a request that was once again denied.

She later asked the gynecologists to please explain to her what a cesarean section consisted of. As an answer, one of them told her "you get in, it's forty minutes, we get the baby out, and that's it" (ibid., p. 29). Her partner was denied entry, stating that "that is an operating room, not anyone can get in" (idem).

Without her consent to any of it, the operation began and was being performed by trainee students. In the Views adopted by the Committee under article 7 (3) of the Optional Protocol, concerning communication No. 149/2019, made by the United Nations' – hereafter, UN – Committee (CEDAW, 2022, p. 3), Nahias's testimony is collected:

> “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”.

Once her son was born, medical staff, upon ordering her to give him a kiss, immediately took him away to another room, not allowing for skin-to-skin contact to be made (Alkorta, 2023), while Nahia was taken a different one, known as the “awakening room”, where she is supposed to recover from the operation. She asks many times for her baby to be brought to her, but to no avail.

2.3. Postpartum.

About four hours later, when Nahia was finally being brought to the room where she would recover for the next three days, she encountered her parents, who had not known where she had been or if she was okay, and the first thing she said after asking for her baby was that she hadn’t signed anything.

At last, the baby was brought to her, who she found out had been bottle-fed and had an unpleasant smell, as if chemicals, soap or perfume had been applied to him. She also found out the staff had put their son in a crib by himself, and his father was not allowed to see the baby, and was only allowed entry after firmly insisting. Even then, they did not allow him to pick the baby up, and it was only after they brought their son to Nahia that he finally had skin-to-skin contact, after many hours (ibid., p. 38).

Postpartum was very hard on Nahia. She felt incredibly weak, pained and dependent. She was not able to get up and/or move by herself, not even hold her baby

while laying down. Her baby was put in a crib far away from her bed, which she could not take him out of or put him back in, or even look at him (ibid., p. 37).

When she finally gained courage to ask her husband how he lived the experience after they were separated, he told her a midwife had said to him that "it's been too long already, maybe something happened to her", which led him to think she had died.

The months after the birth of their son were difficult. During the first weeks after her discharge from the hospital, she found refuge in her parents home. She was still unable to function by herself, she bled a lot, and the scar was painful (ibid., pp. 42-43).

In her book, Nahia talks about the rejection her child's smell caused her, and the many times she doubted if her son was indeed hers. She also mentions feeling abandoned during the aftercare provided by the doctor's appointments, as they consisted in removing the gauzes and not much more, not even any vaginal check.

2.4. Aftermath.

"All of this should not have happened" is what Nahia's private gynecologist told her in an appointment, and it was then that she started looking for answers. She started investigating and joined a support list called "Apoyocesáreas", pertaining to the "El Parto Es Nuestro" association, where she found comfort and support in other women and their stories.

Over time, not only her physical pain and discomfort persisted, but also the psychological effects, which led her to make a doctor's appointment, from which she was referred to the psychiatrist, and in June 2013, she was diagnosed with post-partum post-traumatic stress disorder, anticipatory distress and anxiety, emotional instability and reactive depression (CEDAW, 2022).

It was when Nahia requested a copy of her medical record, that she realized that many things that had happened were not adding up. For example, when bottle-feeding her baby in the hospital, when faced with her husband's denial, the staff claimed that

they had to do so, as the baby's glucose was low, which was proved to be a false claim, as the blood glucose test they had done on him showed a normal result.

Consequently, she decided to contact lawyer Francisca Fernández Guillén, who from the beginning told her it would be very difficult to win the case. Nahia and her partner decided to go on with it, and requested a midwife who had assisted in the labor to evaluate her medical history, who sustained, among other things, that there had been no medical reasons to perform many of the procedures that had been performed.

In July 2013, she filed a claim against the Basque Health Service demanding financial responsibility for the care she received during her birthing process, to which she received no answer. She proceeded with filing a claim to the Administrative Litigation Court Number 3 of Donostia - San Sebastián against the brushing off of the first claim, which was also dismissed.

She then made an amparo appeal – an appeal for constitutional protection of fundamental rights – to the Constitutional Court of Spain, which was not granted leave. All of this led Nahia, along with her lawyer, to take this matter to the Committee (CEDAW, 2022, p. 17), which in 2022 concluded that:

> "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; [...]".

However, even though the Committee recognised the violation of Nahia's rights and requested that Spain compensate her – not only financially –, the State's response hasn't been what Nahia would've liked it to be.

In July 2022, the Department of Health of the Basque Government and Osakidetza issued a press release in which it is stated that, as the resolution of the appeal made to the Administrative Litigation Court Number 3 of Donostia - San Sebastián sentenced, no physical or psychological harm had been done to the patient and all care provided followed protocols and regulations. Furthermore, it added that the Department seeked that the process of labor/birth be a positive and unforgettable experience while striving for excellence and safety (Gobierno Vasco, 2022).

As of today, outside of the press release issued by the Department of Health of the Basque Government and Osakidetza, Spain has yet to give a response about this matter and/or take any kind of restorative and compensatory actions. And thus, Nahia once again finds herself in the position of having to appeal – once again – so that the state reacts and complies with, at least, that which has been requested by the Committee, with all the economic and psychological effort that encompassess.

3. THEORETIC APPROACH TO OBSTETRIC VIOLENCE.

3.1. Defining and understanding the concept of obstetric violence.

The World Health Organization – hereafter, WHO –, in its statement "The prevention and elimination of disrespect and abuse during facility-based childbirth" (WHO, 2014, p. 1) declares 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".

Despite this, the – controversial – discussion around obstetric violence does not start at defining what constitutes this type of violence, but at questioning the adequacy, use and existence of the term "obstetric violence" itself.

Obstetric violence, as per Van der Waal et al. (2023, p. 1), is defined as:

> "a global phenomenon and takes place at the hands of obstetric health workers during any encounter in the prenatal, intranatal, and postnatal period. Obstetric violence

> consists of, but is not limited to, physical, verbal, sexual, structural, and epistemological forms of violence, such as nonconsensual procedures, neglect, gaslighting, surrogate decision-making, shaming, and discrimination [...].”

Another definition, provided by Mir and Gandolfi (2021, p. 1) conceptualizes obstetric violence as:

> “Obstetric violence refers to practices and behaviors carried out by healthcare professionals on women during pregnancy, childbirth and the postpartum period, in the public or private sphere, which by action or omission are violent or may be perceived as violent. It includes inappropriate or non-consensual acts, such as episiotomies without consent, painful interventions without anesthesia, forcing them to give birth in a certain position or providing excessive, unnecessary or iatrogenic medicalization that could generate serious complications. This violence can also be psychological, such as giving the user childish, paternalistic, authoritarian, contemptuous, humiliating, verbal insults, depersonalized treatment or contempt”.

The term has received pushback worldwide, not only from the medical and scientific communities, but also scholars, academia members and legislative powers. In many cases, the latter do not recognize obstetric violence in their legal framework, mainly because of political reasons in addition to the pressure of the medical community.

According to the WHO’s “World report on violence and health” (2002, p. 5), violence is defined as:

> "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation".

When defining violence, the use of the word “intentional” sparks debate, and is one of the main arguments of those who claim that by framing as intentional the mistreatment of women during childbirth at the hands of healthcare professionals, it implies that these professionals willingly subject women to harm.

Lappeman and Swartz (2021, p. 9) argue that “labeling health care systems and practitioners as violent (as opposed to untrained, insensitive, or incompetent, or even structurally positioned as having power they themselves may be unaware of or may not want, for example) has far-reaching consequences for their emotional health and the system of people required to maintain health care professions and services” and that in doing so, chances for improvement – in the context of obstetrics – are minimized.

However, this statement implicitly assumes that obstetric violence is enforced by healthcare professionals individually and exclusively, and fails to recognize that, while in some cases that might be – and is – true, the root of this issue lies within a social system based on a patriarchal hierarchy, the systems of power – i.e. gender, race, class – and is a structural and institutional problem.

With the use of obstetric violence, feminist activists, organizations, scholars and professionals don’t intend to put the blame on healthcare professionals individually, but to accentuate and criticize the role and relevance of the system’s intrinsically problematic sociostructural configuration (Chadwick, 2021).

Additionally, while valid arguments are made debating the semantic accuracy and precision of the term, it must be noted that, while a exact and accurate definition is difficult to achieve, that lack of consensus must not mean that attempts to properly define it should be ruled out, as this would make obstetric violence and the struggle against it even more under-recognized, since in many instances, that which is not named does not exist.

As Chadwick (2021, p. 7) states, “the language of obstetric violence is not meant to be comforting to health care practitioners but aims to generate discomfort in the hope of triggering critical and transformative reflections about normalized practices”.

3.2. Obstetric violence and medical malpractice.

Often, obstetric violence is confused with and understood as medical malpractice in the field of obstetrics, and though both concepts may be present in some

women's experiences, medical malpractice is not a necessary requisite for obstetric violence.

The World Medical Association released a statement (WMA, 1992, p. 1) that was adopted in Marbella, Spain, in September 1992 and later rescinded in 2005. In this statement, the WMA conceptualizes medical malpractice as:

> "Medical malpractice involves the physician's failure to conform to the standard of care for treatment of the patient's condition, or a lack of skill, or negligence in providing care to the patient, which is the direct cause of an injury to the patient".

In addition to this, the consequence of the malpractice must be quantifiable and disproportionate or considerable damage and it is on the patient to prove that the harm caused was because of the medical act or omission. Manifestations of medical malpractice can be: wrong or late diagnosis, failure to correctly carry out procedures, medication errors and failure to provide adequate aftercare, among other things.

Indeed, the instances listed can – and do – happen in obstetric care, as medical staff sometimes fail to meet the necessary and required standards of care. However, the existence of medical malpractice in the field of obstetrics should not be equated to obstetric violence.

If a surgeon carrying out a cesarean section fails to properly disinfect the tools used, resulting in an infection, this would constitute malpractice as they did not meet the required standard of care, but would not necessarily add up to obstetric violence.

This is because obstetric violence, rather than an exceptional occurrence, is a structural and institutional problem. Unlike malpractice, whose root cause is the individual action of a healthcare professional, obstetric violence is a phenomenon that comes as a consequence of the actions – or lack thereof – of the medical and scientific community and the state.

Obstetric violence accounts for the lack of knowledge or information regarding appropriate obstetric care, the normalized harmful practices, the dismissive, aggressive

or violent way of communicating, the unwanted – or denial of wanted – performances of procedures, the lack of or ineffective legal regulations, etcetera. And while these actions might not necessarily result in quantifiable damage – which they sometimes do – as a direct consequence, they do result in violence and harm nonetheless. A violence and harm that should not go unaddressed.

Consequently, in some instances the harm caused to a woman can be traced back to both obstetric violence and medical malpractice, while in others, it can only be traced back to either obstetric violence or medical malpractice, but not both. That is because not all obstetric violence cases constitute medical malpractice, the same way not all medical malpractice constitutes obstetric violence.

4. OBSTETRIC VIOLENCE AND VIOLENCE AGAINST WOMEN.

Many, like Rojas and Hidalgo (2019), Belli (2013), Williams and Meier (2019), Solorio, Barriguete and Campos (2020) and the European Institute of Perinatal Mental Health (2019) believe that obstetric violence constitutes a violation of human rights. The Joint statement of the Obstetric Violence Observatories, which is made up of the Argentinian, Chilean, Colombian, Spanish and French Observatories (2016), declared that "this scourge is a serious violation of human rights, given that women are not recognized as subjects of rights and their autonomy and sovereignty over their body and their sexual and reproductive processes are undermined, while at the same time it attacks their power in decisions around the well-being of their babies".

This should not come as a surprise, as the Vienna Declaration and Programme of Action (1993, p. 4) states that "the human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights" and that "all human rights are universal, indivisible and interdependent and interrelated".

The issue of obstetric violence intersects not only with the right to non-discrimination – whose violation manifests, though not exclusively, via gender-based violence against women –, but also with the violation of various other rights, such as the right to health, the right to bodily autonomy, the right to informed

consent, the right to human integrity, the right to health the principle of equality and more.

However, this paper delves into and focuses on violence against women as the source and origin of this issue, as I believe that while it is most definitely not the only factor, it is the most important one.

4.1. Sex/gender power system.

Taking into account the above, intersectionality[1] is a key element and must be present at all times in order to fully understand not only obstetric violence and its reach, but also the sex/gender system and the consequent gender-based violence against women, as the latter two concepts are not the only factors when it comes to shaping and enforcing it.

This is because, the same way obstetric violence intersects with other rights, the sex/gender system also does intersect with other power systems – be it race, class, sexual orientation, etc –.

Rubin (1975, p. 3) defines the sex/gender system as "the set of arrangements by which a society transforms biological sexuality into products of human activity and through which these transformed sexual needs are satisfied". She later redefines it as "a set of arrangements by which the biological raw material of human sex and procreation is shaped by human, social intervention and satisfied in a conventional manner no matter how bizarre some of the conventions may be" (ibid., p. 9).

On the other hand, the European Institute for Gender Equality (EIGE, n.d.) names it "gender system" and defines it in its glossary as the "system of economic, social, cultural and political structures that sustain and reproduce distinctive gender roles and the attributes of women and men".

[1] Intersectionality, according to the UN's Network on Racial Discrimination and Protection of Minorities (2022, p. 3), "is a concept and theoretical framework that facilitate recognition of the complex ways in which social identities overlap and, in negative scenarios, can create compounding experiences of discrimination and concurrent forms of oppression".

Therefore, the sex/gender system is a power system that has sex and gender as the core foundation of itself, and follows the correlation between those two elements in order to differentiate between men and women, and the gender roles assigned to each one of them.

Bleichmar (1996, p. 17) understands gender as a "fundamentally psychological category, whose origin goes back to the family cell, which is established as one of the coordinates that structure the human subject, constituting a complex and multifactorial system that is currently called the sex-gender system" and differentiates between sex and gender by stating that "under the noun gender, all the psychological, social and cultural aspects of femininity/masculinity are grouped, reserving sex for the biological and anatomical components and to designate the sexual exchange itself" (1985/1997, p. 32).

In a more simple way, the WHO in its website (WHO, 2019) defines gender as "the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy, as well as relationships with each other" and defines sex as "the different biological and physiological characteristics of females, males and intersex persons, such as chromosomes, hormones and reproductive organs".

Koester (2015, p. 3) adds that "Gender roles are power relations. Gender is not only a cause but also a consequence, instrument and embodiment of power-over relations. It is a key mechanism through which power not only constrains but constitutes individuals and is perhaps the most persistent form of 'invisible power' in our world".

Given that gender is a social construct, it must be understood as an inevitably ever-changing concept, as social constructs change given the necessities of the human group that creates it according to certain circumstances and is subjected to evolution over time.

Gender assigns a certain set of characteristics, that can range from behavioral to moral, to a certain group of people and another set of characteristics to the other group of people. That's why there is an expectation that men behave and act a certain way,

while women behave and act another, qualifying everything that goes against this social construct as unnatural, abnormal or deviant.

It is important to note socialization's role when it comes to gender. As Rocher (1990, pp. 133-134) conceptualizes it, socialization is "the process by which the human person learns and internalizes, in the course of his life, the sociocultural elements of their environment, integrates them to the structure of his personality, under the influence of experiences and significant social agents, and thus adapts to the environment society within which he must live".

This process applies to gender, by which we internalize the social dynamics of gender – via gender roles and stereotypes, among other things–, and therefore integrate those dynamics and expectations that stem from our family, community and overall environment, into our personality, resulting in the development of our individual gender identity.

On the other hand, sex is the way that the sex/gender system assigns one of the two genders[2] to a certain person based on the biological and physiological attributes, and is understood as the physical manifestation of a person's gender, according to the sex/gender system. That is to say, under this system, being born with certain physiological characteristics – mainly hormones, chromosomes and genitalia – automatically assigns a gender.

A person born having a higher level of testosterone, the XY chromosomes and male genitalia will mean that that person's assigned sex at birth will be male, while having higher levels of estrogen, XX chromosomes and female genitalia will mean the assignment of the female sex. The sex assigned at birth carries a series of psychological and behavioral expectations, and therefore, an expected gender.

[2] The discussion that focuses specifically on the binarism of sex and gender generally refers to it as the binary sex/gender system. Binarism is inherently intertwined with the sex/gender system, and is the classification of gender that recognizes only two possible genders – identities – woman and man. This constitutes its own debate that cannot be analyzed in this work due to extension issues.

In today's society, someone's whose sex is male and is manly equates being a man, and being female and feminine equates being a woman[3]. In this power system, that distinction is used in order to subdue women and place them subordinate to men, because it regards the attributes deemed as manly as more valuable and therefore designs itself – the system – around men's necessities.

One of the many manifestations and consequences of the sex/gender power system is the violence exerted against women in order to maintain and sustain the system, which is based around the domination of men. Gender-based violence against women will be elaborated further in the next section.

4.2. Defining gender-based violence against women.

In the preamble of the Declaration on the Elimination of Violence against Women –hereafter, DEVAW – (UN, 1993, p. 1), proclaimed by the UN's General Assembly it is states that "recognizing that violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men, [...]".

In addition to that, its 1st article proclaims that violence against women consists of:

> "any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".

[3] This is an idea that is slowly proving to be obsolete, as research and growing public sentiment show that the binarism of gender does not correspond with the reality of gender identity, as a person that is assigned male at birth will not necessarily identify as a man, and one assigned female at birth will not necessarily identify as a woman, in terms of gender.

Gender-based violence against women is generally heavily associated with domestic violence, in which a woman's male partner subjects her to physical and psychological abuse, but in reality, that is not all that violence against women is.

As stated by Sau (1998, pp. 166-167), "individual mistreatment [...] is the particular and specific manifestation of the structural, institutionalized abuse that is part of the patriarchal order. Their own institutionalization makes them go unnoticed and circulate as obvious material for which no explanations or justifications are necessary".

Furthermore, the UN goes on to add in its DEVAW's 2nd article that violence against women includes – but is not limited to – the physical, sexual and psychological violence occurring either in the family or within the general community, and the physical, sexual and psychological violence perpetrated or condoned by the State.

Like obstetric violence, gender-based violence against women is a normalized, institutionalized and a structural and cultural issue. It affects women throughout their entities lives and in all areas of their lives and its impact reaches – but is not limited to – social, legal and healthcare settings.

Institutionalized violence is that perpetrated by the state, whether physical, sexual or psychological or symbolic, abusively exerted by the state in compliance with its functions and/or regulations. As Olmo (2018, p. 4) defines it:

> "the institutional violence is a prototype of violence (understood as a set of actions and effects of pain and physical and mental damage) that can be exercised in a extraordinary or recurrent way, reiterated and systematic manner, against people subject to control and surveillance or custody and internment in any of the spaces of the institutions that develop these functions or in the jurisdictional contour of the themselves, with the action or collaboration of authorities, officials or personnel of entities and companies authorized or contracted by the State for the performance of that type of tasks".

Additionally, for Galtung (2003) violence has three different manifestations, that is known as the triangle of violence: cultural, structural and direct. Direct violence is the

so-called tip of the iceberg, the most obvious and apparent one, exerted by a person onto another one, physically or psychologically.

Structural violence – sometimes used interchangeably with institutional violence –, according to La Parra and Tortosa (2003, p. 1), "refers to the existence of a conflict between two or more groups of a society (usually characterized in terms of gender, ethnicity, class, nationality, age or others) in which the distribution, access or possibility of using resources is systematically resolved to favor of one of the parties and to the detriment of the others, due to the mechanisms of social stratification".

Lastly, cultural violence is a type of symbolic violence[4] and consists of "those aspects of culture, in the symbolic sphere of our experience (materialized in religion and ideology, language and art, sciences empirical and formal sciences – logic, mathematics – symbols: crosses, medals, stockings moons, flags, anthems, military parades, etc.), which can be used to justify or legitimize direct or structural violence" (Galtung, 2003, p. 7).

Concerning gender-based violence against women, all four subtypes of violence mentioned before – direct, institutionalized, structural and cultural – are applicable to it as it can be exerted by one person onto a woman directly and its existence lies on a society whose structure, institutions, cultures and traditions heavily favor men in detriment of women.

The constant perpetration of gender-based violence against women – be it in a direct, institutionalized, structural or cultural manner – results in the normalization of those violent conducts, making it harder to identify it as such and consequently can go under-recognized.

4.3. Obstetric violence as a form of gender-based violence against women.

[4] As Bourdieu (1999, pp. 224-225) states "symbolic violence is that coercion that is instituted through means of an adhesion that the dominated cannot help but grant to the dominant (and, therefore, to the domination) when he only has at his disposal to think of it and himself or, better yet, to think his relationship with him, instruments of knowledge that he shares with him and that, being nothing more than the incorporated form of the structure of the relationship of domination, make this relationship appear present itself as natural".

At the very core of obstetric violence is the direct, institutionalized, structural and social need, want and/or tendency to disregard women's – bodily – autonomy and rights. As Nahia defined it in the interview, obstetric violence is:

> "is a way of exercising power over women's bodies, from a very medicalized perspective in which, sometimes, excessive interventions are carried out, other times necessary interventions are denied and, generally, it is associated with verbal abuse, whether infantilization, threats, coercion or blackmail. [...] In the end, obstetric violence is simply one more representation of sexist violence that is exercised in an environment in which we should be cared for, and that aggravates it [...]".

Gender-based violence against women is present in all societies of the world, affects all women plainly because they are women and is, essentially, enforced as a means to subdue and control women in order to maintain and assert the superiority of men on all levels possible – whether it is economic, social, etc –.

In its website, the WHO (WHO, 2019) states that "gender influences people's experience of and access to healthcare. The way that health services are organized and provided can either limit or enable a person's access to healthcare information, support and services, and the outcome of those encounters". In the context of obstetric violence, gender-based violence against women manifests in many different ways.

The degrading, paternalizing and infantilizing way of speaking, makes – or tries to make – women look as if they were completely uninformed, and are not capable of understanding any of what is going on or is being told to them. This reinforces the stereotype of women being overly emotional and hysterical beings, that are not capable of reason or logic, which according to patriarchal and sexist reasoning, places men as the ones who should be in charge of any and all kinds of decision-making.

Related to this, the lack of information and the lack of seeking consent from women further reinforces the idea mentioned in the paragraph before. In many instances, healthcare professionals inform and ask the husband or male partner – and even male relatives, like the woman's father – for consent, even when the woman is in the room with them. This is, again, because it is a stereotyped belief that women "in that

state" – referring to pregnancy – cannot be allowed to make decisions regarding herself or her baby and assumes that any man related to her knows better than she does.

This is also why, in those cases, it is not only the healthcare professionals who are not listening and respecting women and their needs, but it is also their husbands, male partners or relatives. These men become directly or indirectly responsible for enforcing obstetric violence – and therefore, violence against women – as some of them do not care about the woman's needs and prioritize their own preferences.

As it is widely known, that overlooking women's needs, wants and preferences in order to cater to men's, is a devastatingly widespread practice that stems from the belief that men are superior to women, situating their demands as more important.

A very frequent medical practice, that reflects this way of thinking, is the one known as the "husband's stitch", which consists of placing another stitch at the vaginal opening after having given birth, for no other reason – no medical or cosmetic purpose – than tightening the opening, in benefit for the husband's sexual preferences. This procedure is often done without the woman's consent or even informing her, and in many other instances, the husband or male partner is also not informed – not that it should be the decisive factor –, which goes to show that this is oftentimes done purely to satisfy the doctor's or healthcare professional's ideas and/or beliefs.

But who, if not the woman herself, could possibly know and want what is better for herself and her baby, if not her? There is a frequently used phrase that says that mothers will do any and everything for their children, but this sentiment somehow does not translate to many areas of life, one of them being pregnancy and childbirth. It is contradictory to claim that mothers will put their children's safety above everything else, even their own, just to strip them of their capabilities when the time to safeguard their kids' well being actually comes.

Consequently, obstetric violence is nothing but another manifestation of violence against women, that serves as a mechanism to undermine women's credibility and subject them to the will of a man-governed society. This is the reason why obstetric

violence can only be utilized against women, since the main reason that predisposes a person to suffer from it is the fact of that person being a woman.

As Martínez (2023, p. 3) states: “On this occasion, when a woman gets pregnant, part of her body stops belonging to her to assist an important social function such as the reproduction of the human species”.

5. OBSTETRIC VIOLENCE IN SPAIN.

5.1. Recognition of the term “obstetric violence”.

In Spain, there were talks in 2021, of introducing different matters via the Organic Law 1/2023, of February 28, which modifies Organic Law 2/2010, of March 3rd, on sexual and reproductive health and the voluntary interruption of pregnancy (BOE[5], 2023)[6] more popularly known as the “Abortion Law”. Initially, one of the main points of this reform, among many other things, was to introduce and legally recognize the term obstetric violence.

In June 2021, the Women’s Institute proposed, among other things, “expanding the framework of women's sexual and reproductive rights by legislating against obstetric violence” (INMUJERES[7], 2021).

On the 12th of July of the same year, the General Council of Official Medical Schools (CGCOM)[8], pertaining to the Spanish Collegiate Medical Organization (OMC)[9], released a page long statement titled “The CGCOM rejects and regards as very unfortunate the concept of “obstetric violence” to describe the professional practices of pregnancy, childbirth and postpartum care in our country” (CGCOM, 2021).

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[5] BOE is the Spanish abbreviation for Boletín Oficial del Estado, which translates into State’s Official Bulletin.

[6] Ley Orgánica 1/2023, de 28 de febrero, por la que se modifica la Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo. Published in: BOE núm. 51, de 01 de marzo de 2023

[7] INMUJERES is the Spanish abbreviation for Instituto de Mujeres, which translates into Women’s Institute, in English.

[8] CGCOM is the Spanish abbreviation for Consejo General de Colegios Oficiales Médicos, which translates into General Council of Official Medical Schools, in English.

[9] OMC is the Spanish abbreviation for Organización Médica Colegial de España, which translates into Spanish Collegiate Medical Organization, in English.

This statement, among other things, claims that the professionals "guarantee the nonexistence of violent acts in patient care", states that recognizing the term would "criminalize the actions of professionals who work under the principles of scientific rigor and medical ethics" and asks to "not to create unnecessary social alarms".

Shortly after, the Spanish Society of Gynecology and Obstetrics (SEGO[10], 2021, p. 1) also released a two page statement agreeing with and adhering to that of the CGCOM, further adding that "We find the term "obstetric violence" inappropriate, biased and unfair because its malicious legal meaning, as well as intention to cause harm, intent to injure, use of force or threats, classifiable as criminal, which we must completely reject. Inappropriate practice should not be confused in any way with unmet birth expectations".

These claims illustrate the reality of where, not only the Spanish, but the worldwide medical community stands, by not only denying the existence of mistreatment suffered by women and equating it with "unmet birth expectations", but also downplaying its importance to the extent of referring to the naming and recognition of the issue as creating an "unnecessary social alarm".

Consequently, the term obstetric violence was left out of the state-wise reform as the Ministry of Equality explained that an agreement had not been reached with the Ministry of Health.

5.2. Current situation.

In addition to the resistance and, therefore, lack of recognition – not only in terms of legality – of the term, the Obstetric Violence Observatory (OVO)[11], pertaining to the association "El Parto Es Nuestro", released a report in 2016 consisting of, among other things, data resulting from a questionnaire answered by 1921 women, to show obstetric violence's reach in Spain.

[10] SEGO is the Spanish abbreviation for Sociedad Española de Ginecología y Obstetricia, which translates into Spanish Society of Gynecology and Obstetrics, in English.
[11] OVO is the Spanish abbreviation for Observatorio español de la Violencia Obstétrica, which translates into Observatory of Obstetric Violence, in English.

Among the information collected, the following stands out: in 50,7% of the cases, women were not informed of the intervention that was going to be performed; in 76.6% of the women were not informed of the alternatives they had; 50.1% of the cases were acted upon without the women's consent; 65.8% of women's birth plans were not respected; in 42.7% of the cases, women did not have free access to their babies; and 35.9% of women had needed or believe they need therapy or psychological help to overcome the birth's after-effects (OVO, 2016).

Another research (Mena-Tudela et al., 2020) consisting of 17.541 questionnaires, shows the following data: 38.3% of women believed they had suffered obstetric violence; 45.9% were not asked to give express consent, nor were they informed about the procedures performed on them; in 44.4% of the cases, women felt like they had undergone unnecessary and/or painful procedures, 83.4% of which were not asked to give consent; and 35.0% of women did not feel supported after the birth "m in the questions about feed and baby care" .

These data illustrate how discontent and dissatisfaction with the care provided during childbirth and postpartum is not an isolated case or that only few are subjected to obstetric violence, as almost 40% of women believe they have suffered it (Mena-Tudela et al., 2020). On the contrary, these data are alarming and go to show how despite the medical community's denial and the state's unresponsiveness and lack of action, obstetric violence is a prevalent issue in Spain.

In fact, Nahia's is not the only case that has reached international courts. There are another two instances that, also coming from Spain, have reached the Committee.

In one of those other two cases, S.F.M.'s case, the mother was subjected to ten digital vaginal examinations, which was probably the reason why her daughter had a temperature of 38.8°C, as too many examinations of this kind lead to a higher risk of infection. She was given oxytocin, which led to vomiting and a fever, on top of other resulting secondary effects, and was also, along with her partner, denied access to their baby. All of which was done without consent being sought from her, and resulted in post-traumatic stress disorder (CEDAW, 2020).

In the Decision made by the Committee in February 2020 (CEDAW, 2020, p. 3), S.F.M.'s statement in court was reproduced:

> "Going into hospital was like going into a car wash or onto an assembly line; everyone does things to you in a mechanical way. The woman does nothing, but she comes out of the car wash with a baby. Although the same thing happens in other types of medical assistance, like, for example, a heart operation, where the patient doesn't have to do anything and is prepared for passivity, in childbirth a woman is physically and psychologically prepared to give birth, not for others to deliver the baby for her. I felt disempowered, with no self-esteem. I had to create the bond with my daughter the hard way, rationally, without the help of the complex natural neurological and hormonal mechanisms that make mothers fall in love with their newborn children".

M.D.C.P's case was similar in many ways. She was also, despite her pre-existing medical condition, denied medication – and water – and given oxytocin. The administration of epidural analgesia took ten attempts, eventually resulting in lasting neck and back pain. Hers, like Nahia's and S.F.M.'s, was also a rushed birth via cesarean section despite the normal and satisfactory progress of the labor process. The experience subsequently led to a post-traumatic stress disorder (CEDAW, 2023).

All three of them, having exhausted domestic remedies, turned to the Committee in hopes of justice being done. However, despite all three cases decisions made have been favorable to the claimants, Spain's refusal to act – or react, at least – is notorious. It is also worthy to note, that as of 2024, Spain is the only European state member found guilty in regards of obstetric violence by the Committee.

It is, however, important to mention the work and activism done by the previously mentioned "El Parto es Nuestro" association. It is a feminist nonprofit that works towards making pregnancy, birth and postpartum a positive and a better experience overall for women. It offers many women across the country a place to tell their stories, be heard, supported and provides many resources to deal and handle their experiences.

Given that obstetric violence is a relatively new concept, it has had a minimal amount of studies and research done about it worldwide, though it is slowly becoming a more notable topic in academia.

On this matter, Goberna-Tricas (2019, p. 9) states that "a broader analysis is necessary, focused on the cultural and social dimensions in which the phenomenon of obstetric violence is embedded, which may allow a change of view that is no longer limited to the victims (women) and perpetrators (health professionals) to expand the look towards the recognition of the ubiquitous socialization of men and women in naturalized, and therefore invisible, forms of violence and power dynamics between groups".

On a similar fashion, Ramos and Ávila (2017, p. 17) add that "if we conceive childbirth as a biosocial, historical and cultural process, it can be understood that this process can be changed and improved and, for this, studies are necessary that reveal risk and protection indicators, and negative and/or improvable practices that can make childbirth a further stage of human nature, in this case, the nature of women"

As mentioned on section 3.1. of this work, a considerable amount of the discussion revolves around the recognition and adequacy of the term and, therefore, that is what a big part of academia focuses its efforts on. Goberna-Tricas (2019) affirms that putting a name on obstetric violence has made it possible to situate the issue in the public eye rather than pinpointing it to individual healthcare professionals' action.

On a similar note, Sánchez (2015, p. 16) explains that "the fact that today a concept such as "obstetric violence" has appeared and there are specific laws dedicated to minimizing the impact of the medicalization of the bodies of women and babies at the time of childbirth, tells us about the need to investigate in the causes and solutions to this reality, much more complex than apparent".

On their part, Mir and Gandolfi (2021, p.1) affirm that "this is an innovative issue, with few studies in Spain, where obstetric violence can take numerous forms and can sometimes be underestimated under postpartum depression syndromes or

post-traumatic stress. This is a very little-addressed problem, especially regarding the perception of users and health professionals".

A study conducted by Iglesias et al. (2019, p. 17) on a sample of 17677 women shows that "although certain health professionals and scientific societies deny the existence of OV (Spanish Society of Gynecology and Obstetrics, 2018), or sometimes consider it "necessary" to ensure maternal-fetal well-being, there are many women who perceive that the health care they have received received is deficient in quality and scientific rigor, and they identify numerous aspects for improving care in the obstetric process both from a technological and human point of view".

On the other hand, Suárez (2023, p. 15) says that a solution to this issue of care for women regarding their reproductive health "must begin by admitting the hypothesis that dehumanized care at a time of special vulnerability such as childbirth has the potential to leave a deep emotional mark on a woman's life".

Having conducted a bibliographical revision on academic production regarding obstetric violence in Spain, it can be concluded that, in this case, Spanish research and studies are few, which highlights the aforementioned novelty of the topic. However, what the vast majority of academics agree on is that obstetric violence must be named and defined – which has proven to be complicated –, is yet another form of discrimination based on gender against women that, in this case, manifests in healthcare settings, is an issue that has gone unaddressed and that could – and should – be prevented, as is not rooted inherently to the medical profession but in the sociocultural norms and gender stereotypes that are harmful to women, and that further research is needed for proper study of this issue.

6. INFORMED CONSENT IN THE CONTEXT OF OBSTETRIC VIOLENCE.

6.1. Defining the concept.

To get a closer look as to what informed consent is understood as in Spain, it is interesting to refer to the Committee of Experts on Informed Consent of the Department of Health of Navarra (1997, p. 2), which delineates informed consent as "today it is

commonly accepted that informed consent is a gradual and verbal process within the doctor-patient relationship, by virtue of which, the patient agrees, or not, to undergo a diagnostic or therapeutic procedure, after the doctor has informed him in sufficient quality and quantity about the nature, risks and benefits that it entails, as well as its possible alternatives".

On the other hand, Chill, Dior and Shveiky (2019, p. 1) state that "in theory, the process of informed consent should educate patients regarding the procedure they are about to undergo, disclose benefits and risks, and eventually help patients reach an autonomous decision, implementing their right to self-determination".

This means that informed consent is a means by which healthcare professionals provide all relevant information concerning a procedure to the patient, adequately informing them of the benefits and potential risks or side effects and informing the patient of the existing alternatives. This way, the patient is able to freely decide what is best for them, allowing them the opportunity of autonomous decision-making.

In the context of obstetrics, informed consent should necessarily be sought from the patient – as should in all other contexts in healthcare –, and healthcare professionals should provide them with information regarding all the procedures that affect the mother and her baby, like the different ways of delivery available depending the specific circumstances of the patients and tests performed to monitor the baby's and the labor's progress.

The validity of informed consent depends on five elements: capacity, disclosure, understanding, voluntarism and decision (Del Carmen and Joffe, 2005). In other cases, it is understood that three are the elements required in order to obtain valid informed consent from a patient: capacity, information and voluntarism (Cocanour, 2017).

This is because the five elements mentioned can be subsumed in the other three, as some concepts like the capacity and understanding on the one hand, and voluntarism and decision on the other, are very interlinked and are sometimes understood together and therefore go by the same name.

In the first place, the patient must have capacity to make healthcare related decisions, which does not necessarily mean that the patient is legally competent to make those decisions, as capacity refers to the medical ability of making decisions while competency refers to the legal ability of making them. Once it is determined that the patient is capable, healthcare professionals must disclose the information relevant to the procedure, in a way that the patient understands the information provided. Finally, voluntarism and decision refer to the patient's ability to make a decision without being coerced in any way and subsequently allowing the healthcare professional to perform a certain procedure (Del Carmen and Joffe, 2005).

However, despite informed consent being a medically and legally recognized concept, when it comes to the field of obstetrics, several doubts start emerging. As Blake (2020, p. 2) states, "legally, a patient either has the capacity to consent or they don't, but in obstetrics, there seem to be a lot of grey areas in between those two states".

The main alleged concern is regarding the woman's capacity to make decisions, as labor is a painful and distracting situation, which can decrease her understanding of the information provided. Consequently, alleging that women cannot be capable during labor – and linked with the idea mentioned regarding the sexist stereotype of women being overly emotional and incapable of logic –, many healthcare professionals don't view necessary seeking informed consent seeing as it would be invalid.

That a woman in labor's capacity and/or ability to understand and process information can be compromised to some degree is a fact I don't argue. Pregnancy and labor pose specific challenges, as a pregnancy that has evolved without problem can become a risky birth unexpectedly, becoming an issue both for the mother and the healthcare professional. Despite this, "research shows that recall is not hindered by pain level or opioid premedication" (Broaddus and Chandrasekhar, 2011, p. 1).

It is Brooks and Sullivan's (2002) opinion that the majority of women during labor remain capable and have the capacity of making decisions, and therefore, consent or refuse procedures. In addition, Black and Cyna (2006) disagree with the idea that a being in labor prevents a woman from being fully informed. On the contrary, they state that she should still be informed to the extent possible which makes her consent or

refusal valid. On top of this, Chien (2017) claims that even when it comes to a low-risk pregnancy there is still risk, and therefore healthcare professionals must not assume that vaginal delivery is the patient's default choice.

For this reason, the pain or other symptoms that women may experience during pregnancy and labor does not exempt healthcare professionals from their obligatory task and responsibility of seeking informed consent from patients in the most appropriate way possible, which tends to be overlooked because of the urgency of labor.

Doctor[12]-patient relationship is another reason informed consent might not be sought by healthcare professionals. It is accepted that healthcare professionals have medical knowledge that the patient does not have, thus placing doctors in a position of power. The unbalanced knowledge of medicine in the dynamic makes the patient reliant on trust.

Trust in the doctor-patient relationship is implicit in nature, given that it is normally not explicitly discussed. The patient automatically assumes that it is the doctor who knows better about their medical situation and therefore trusts them and gives the approval to act based on that knowledge, generally assuming the well-meaning intention of the doctor (Skirbekk et al., 2011).

Again, this dynamic in obstetric care has another element to take into consideration. When it comes to pregnant women, the mother does not care exclusively for her well-being, but also of the well-being of her child. In fact, most women tend to place their baby's needs and well-being above their own, which raises exponentially the concern felt by mothers in these cases, in comparison to the concern felt by patients in other medical contexts.

Because the mother feels the need to prioritize and take care of her baby, the difference in the power ratio between her and the doctor is much more notable, as she feels the need to comply with the doctor's commands, fearing that otherwise she may harm the baby.

[12] In this context, when referring to doctors, other healthcare professionals are included too.

The pressure of protecting the baby – together with other pregnancy and/or labor symptoms – often translates in the mother wanting to know the reason why certain procedures have to be performed and how they might affect her and the child. This can be perceived by doctors as the mother questioning their knowledge, experience and professionalism, which results in a more assertive way of communicating and actions. This leads to doctors dispensing with asking for consent and justifying their mode of action by claiming that, as doctors, they have to put their patients welfare and security above their – the patients' – preferences.

6.2. The lack of informed consent and its consequences.

Informed consent should be the basis and the foundation in which healthcare is built in order to achieve better and more satisfactory care, and thus seeking informed consent should not be seen as expendable. The lack of informed consent not only jeopardizes the patient's well-being, but also discredits healthcare professionals' ability to satisfactorily perform and damages trust and other aspects of the doctor-patient relationship.

In that sense, as a mother, feeling as though she is not being heard, talked to and consulted before proceeding, might exacerbate her feeling of helplessness and make her feel as though she is under the care of somebody who does not care about her. This could aggravate and heighten her sense of uneasiness and nervousness which could reflect in her physical status, showing up as dizziness, discomfort, etcetera.

In the least serious cases, where the lack of informed consent has not resulted in very significant damage to the patient, the consequences might be that the patient might not be feeling at ease with their healthcare professional or in healthcare settings anymore, anxiety, and other aspects that might damage the doctor-patient relationship and the implicit trust.

In more serious cases, significant damage can result from the lack of informed consent. This damage does not only affect the patient psychologically, but also might hurt them physically. As seen in Nahia's, S.F.M.'s and M.D.C.P.'s cases, the lack of informed consent not only altered how they viewed and therefore behaved in the

doctor-patient dynamic, but also resulted in lifelong trauma, post-partum post-traumatic stress disorder, anxiety, depression and many other psychological and physical consequences that affected them not only in relation to their health but the rest of the aspects of their lives too.

Furthermore, Gallego (2019) states that, in healthcare settings, the right to autonomy and informed consent are the ones that guarantee women's status as subjects of law. She goes on to add that, according to surveys, a considerable amount of women have had their right to autonomy and informed consent violated, as a consequences of healthcare professionals not seeking consent from and/or informing patients, in addition to many of them feeling as though as they had no ability to make decisions and/or express their opinions.

7. LEGAL FRAMEWORK.

7.1. Analysis of comparative and international law.

On violence against women, the 2011 Istanbul Convention (Council of Europe, 2011) was the first European binding legal instrument, and it is considered the most extensive and far-reaching on this matter. In it, violence against women is considered a human rights violation and aims to contribute to its elimination in all of its forms, protect women against it and create a framework to protect and assist victims .

On an international scope, the 1995 Beijing Declaration and Platform of action – pursuant to the Vienna Declaration and Programme of Action – is the most comprehensive international instrument on gender equality, and strives for the empowerment of women, declares that women's rights are human rights and defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (UN, 1995, p. 35).

As mentioned in section 4, obstetric violence constitutes a violation of the right to health. On this matter, the Constitution of the World Health Organization (WHO, 1946, p. 1) states that "the enjoyment of the highest attainable standard of health is one

of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

The right to health is also contained in the 1965 International Convention on the Elimination of All Forms of Racial Discrimination, the 1948 Universal Declaration of Human Rights, and the 2000 Charter Of Fundamental Rights of the European Union, among other international legal instruments.

On another hand, the Office of the UN's High Commissioner for Human Rights released a document "Fact Sheet No. 31", which aims to shed light on the current state of the right to health under international human rights legislation.

Specifically focusing on women's right to health, the 1979 Convention on the Elimination of All Forms of Discrimination against Women – hereafter, the Convention – states in its article 12 that:

> "1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
>
> 2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".

On the other hand, the 1966 International Covenant on Economic, Social and Cultural Rights, on its 10 (2) article declares that:

> "2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits".

In addition, the 1993 Declaration on the Elimination of Violence against Women states on its 3rd article that:

> "Women are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. These rights include, inter alia : [...] (f) The right to the highest standard attainable of physical and mental health; [...] ".

These articles mention specifically the need to ensure adequate healthcare and protection regarding pregnancy, partum and postpartum. It could be argued that, while they do not specifically mention obstetric violence, it could be interpreted that care that does not meet this basic standard could – or should – be considered as such.

However, it must be noted that instruments that offer special protection, generally do so in hopes of safeguarding the function of reproduction – as seen in the preamble of the Convention – and not so much in order to protect women as people. That is to say, it seems as if the main goal is not to protect and safeguard women's well-being as a particularly vulnerable group of people, but more so to ensure reproduction, making the protection of women a collateral measure and not the main reason for this protection.

For example, the Convention states in its preamble that "bearing in mind the great contribution of women to the welfare of the family and to the development of society, so far not fully recognized, the social significance of maternity, [...] and aware that the role of women in procreation should not be a basis for discrimination [...]" (UN, 1979, p. 2).

That being said, this should not undermine the importance of the explicit recognition of women's right to health, specifically during pregnancy, partum and postpartum, as it marks the first steps towards specific obstetric violence recognition, regulation and subsequent punishment.

It is extremely important to refer to the work done by the UN's Special Rapporteur on violence against women, Dubravka Šimonović. In 2019, she submitted a report named "A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence". This report is the first UN text to focus specifically on obstetric violence, as

it focuses on mistreatment and violence in reproductive health services, particularly during childbirth and obstetric care.

In the report, she states that the mistreatment and obstetric violence have yet to be fully addressed from a human rights point of view and clarifies that when referring to obstetric violence, it means violence experienced by women during facility-based childbirth, and affirms that while countries in Latin America have legislated about obstetric violence, it is not a popular term in the international legal framework on human rights. Furthermore, it notes the difficulties when defining and measuring violence against women during facility-based childbirth as a challenge in addressing obstetric violence.

The Special Rapporteur's report is crucial as it expresses that mistreatment and violence against women in reproductive health services – which includes obstetric violence – are widespread and systematic in nature and that such mistreatment and violence are part of a continuum of violations within the context of structural inequality, discrimination, and patriarchy. She then enumerates a non-exhaustive list of manifestations of this mistreatment and violence provided by over 128 states, interdependent institutions, non-governmental organizations and academics.

The report also identifies the root causes of this issue as: the health systems conditions and constraints, discriminatory and harmful laws, practices and gender stereotypes and the abuse of the medical necessity doctrine and power dynamics.

Šimonović also highlights the importance of informed consent in contributing to respecting women's autonomy, right to make decisions about their own bodies and ensuring that women receive respectful and dignified care and states that the lack of informed consent in healthcare settings not only can lead to mistreatment and violence against women but also may amount to the violation of women's – human – rights, torture and inhumane and degrading treatment.

It is noteworthy to mention that the Special Rapporteur proclaims that "States parties also have an obligation under the Convention on the Elimination of All Forms of Discrimination against Women to pursue, by all appropriate means and without delay, a

policy of eliminating discrimination and gender-based violence against women, including in the field of health. This is an obligation of an immediate nature and delays cannot be justified on any grounds, including economic, cultural or religious grounds" (UNHRC[13], 2019, p. 6).

Lastly, the report underlines the significance of utilizing the international and regional human rights framework to address mistreatment and violence in reproductive health services and calls for the protection and promotion of women's – human, sexual and reproductive – rights by requiring the states to address and pay specific attention to the issue and, subsequently, act within the human rights framework, and gives recommendations to both states and stakeholders.

Despite this report, the international regulations and efforts on protecting women's rights, women are still very disadvantageously placed in society, and a large number of them continue to suffer the violation of their human rights and specifically in healthcare settings because of the discrimination they suffer based on their gender[14].

7.1.1. International regulation and its limitations.

In this sense, it is clear that extensive work has been done by international organizations and states in order to proclaim women's human rights, which include the right to health and sexual and reproductive rights, it can be concluded that it is too broad of a framework.

That is to say, the lack of specificity when it comes to obstetric violence supposes that concepts like women's right to health or autonomy are too general, and thus are oftentimes too ambiguous. This lack of precision leaves room open for interpretation and loopholes, resulting in a difficulty to address the specific and unique elements of obstetric violence and its nuances.

[13] UNHRC is the abbreviation for United Nations' Human Rights Council.
[14] As said previously on this paper, gender is not the only reason women are discriminated against in healthcare settings, as the discrimination based on gender almost always intersect with discrimination based on race, class, religious beliefs and ideas, sexual orientation and even physical appearance, inter alia.

Furthermore, this broadness also implies that states can claim they are upholding, for example, women's right to health or autonomy, because being the concepts and terms so unspecific, it does not take much to be able to claim the compliance with the obligation to protect these rights, even if harmful practices and obstetric violence are still prevalent, since in very general terms, it can be interpreted that the rights referred to in the legal instruments are being promoted and protected. Therefore, the lack of specificity is an essential component in allowing the hindrance of the complete protection and promotion of women's rights.

Moreover, another limitation is the difficulty of enforcing the existing legal instruments. For example, all documents emanating from the UN's General Assembly are recommendations that are not legally binding and rely on the states' participation. More times than not, this translates into a lack of transparency when reporting whatever it may be, thus allowing them to downplay the role and relevance of the cultural, structural and institutional issues that contribute to the violation of rights and the subsequent lack of accountability.

This is specially important since the main instruments that – even though in a broad way – address, among other things, violence against women, women's human rights and their right to health, like the Convention, the DEVAW, the 1948 Universal Declaration of Human Rights, the 1995 Beijing Declaration and Platform of action, among many others, are not legally binding.

Similarly, international monitoring mechanisms, besides their disadvantage of relying on the participation of states, are poorly resourced and consequently cannot focus specifically and in a sufficient manner – or at all – on issues that are not even recognized or a major focus, such as obstetric violence, leaving this problem to fade into the background and stay unaddressed and unresolved. Additionally, states tend to resist external intervention, such as investigations, especially if those interventions could result in the need of changing legislation and practices that are deeply ingrained in sexist, harmful sociocultural norms and practices.

In this case, women have historically been deprived of their bodily autonomy and rights in general when in healthcare settings, which often results in obstetric

violence to some extent, and states have systematically downplayed the importance of this issue, hence, allowing for intervention in this matter would unavoidably call for a change in how women's rights are approached, promoted and protected in healthcare settings, which would in the first place mean that states would have to be held accountable and take blame. Not taking the blame is the default response from states when demanding solutions, since states generally want to avoid reputational damage at all costs.

Given that even the term obstetric violences is a very controversial and discussed topic, it should come as no surprise the fact that there are not many international regulations specific to it. However, there have been some states that have regulated obstetric violence.

Venezuela was the first country to legally recognize and criminalize obstetric violence in it the articles 15 and 51 of its Organic Law on the right of women to a life free from violence (GORBV[15], 2007). Article 15 considers obstetric violence as a form of gender-based violence against women and defines it as:

> "Obstetric violence is understood as the appropriation of women's bodies and reproductive processes by health personnel, which is expressed by a dehumanized treatment, in the abuse of medicalization and pathologization of natural processes, resulting in the loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting women's quality of life negatively impacting women's quality of life" (GORBV, 2007).

Very similarly, Argentina also has recognized it as a form of violence against women in its Law 26.485 for the integral protection of women (2009) and its 6th articles states that:

> "Obstetric violence: that which is exercised by health personnel over women's bodies and reproductive processes, expressed in dehumanizing treatment, abuse of medicalization and pathologization of natural processes, in accordance with Law 25,929".

[15] GORBV is the Spanish abbreviation for Gaceta Oficial de la República Bolivariana de Venezuela, which translates into Official Gazette of the Bolivarian Republic of Venezuela, in English.

In other Latin American countries obstetric violence has also been recognized and is an offense, such as Mexico[16], Ecuador[17] and Uruguay[18]. There is however very little international legislation – be it from countries or international organizations – on obstetric violence.

Therefore, it can be concluded that while, slowly, steps have been taken to protect women, many more steps are needed in order to progress towards a society in which, de jure and de facto, women's rights in healthcare are ensured, protected and promoted, and when not, states are held responsible, making the path to change less obstructed.

7.2. Spain and its legal framework for obstetric violence.

Unlike many Latin American countries, Spain has yet to even legally recognize the term obstetric violence. As mentioned in section 5.1. of this paper, there had been an intention in 2021, of legally recognizing obstetric violence via a reform to the popularly known "Abortion Law"[19], which eventually did not happen.

Therefore, to this day there is no specific regulation on obstetric violence, which makes holding healthcare professionals, hospitals and the state accountable very challenging, since there are laws on patients' rights and informed consent, but those do cannot adapt to the nuances and specificities that obstetric violence entails, making compensation and the measures taken inadequate and unsatisfactory.

Nonetheless, it is worth mentioning that the autonomous regions of Catalonia, the Valencian Community and the Basque Country, explicitly include the term "obstetric violence" in their autonomous regulations.

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[16] In its Ley de acceso de las mujeres a una vida libre de violencia del distrito federal, published in: Gaceta Oficial del Distrito Federal el 29 de enero de 2008.
[17] In its Ley para prevenir y erradicar la violencia contra las mujeres, published in: Registro Oficial Suplemento 175 de 05-feb.-2018.
[18] In its Ley 19.580: Ley de violencia hacia las mujeres basada en género, published in: Diario Oficial Nº 29.862 - enero 9 de 2018.
[19] See section 5.1. of this paper.

Catalonia does so in its Law 5/2008, of April 24, on the Right of Women to Eradicate Gender-based Violence (BOE, 2008)[20]. The recognition and definition of the term was introduced via Law 17/2020, of December 22, in amendment of Law 5/2008, on the Right of Women to Eradicate Gender-based Violence (BOE, 2021)[21].

The 4th article of Law 5/2008, declares that obstetric violence and the violation of sexual and reproductive rights:

> "consists of preventing or hindering access to truthful information, necessary for autonomous and informed decision-making. It can affect the different areas of physical and mental health, including sexual and reproductive health, and can prevent or hinder women from making decisions about their sexual practices and preferences, and about their reproduction and the conditions under which it is carried out, in accordance with the instances included in the applicable sectoral legislation. It includes forced sterilization, forced pregnancy, the impediment of abortion in the legally established instances and the difficulty in accessing contraceptive methods, methods for the prevention of sexually transmitted infections and HIV, and assisted reproduction methods, as well as gynecological and obstetric practices that do not respect women's decisions, bodies, health and emotional processes".

While recognizing the term explicitly is a very important first step towards further legislation about obstetric violence, especially given the resistance, it can also be recognized that the definition provided by this article could be a little more detailed. A very overlooked and probably one of the most frequent elements of obstetric violence is the dismissive, infantilizing, aggressive and humiliating way of speaking of healthcare professionals towards women. This definition is mostly focused on the procedural side of it, which could lead to the impression that the way of speaking and communicating does not affect women and their experience and therefore might be understood that it does not constitute obstetric violence.

The Valencian Community also explicitly names obstetric violence in the 59th bis article of the Law 10/2014, of December 29, on Health of the Valencian Community.

[20] Ley 5/2008, de 24 de abril, del derecho de las mujeres a erradicar la violencia machista. Published in: BOE núm. 131, de 30 de mayo de 2008.
[21] Ley 17/2020, de 22 de diciembre, de modificación de la Ley 5/2008, del derecho de las mujeres a erradicar la violencia machista. Published in: BOE núm. 11, de 13 de enero de 2021.

It claims that women have the right to, among other things, "ensure measures to combat obstetric violence as defined by the World Health Organization (WHO)" (BOE, 2014)[22]. This is however a tricky recognition of the term, since the WHO does not have an official definition for obstetric violence, which makes room for ambiguity.

Lastly, the Basque Country also recognizes explicitly, in the 44th article of the Legislative Decree 1/2023, of March 16, which approves the consolidated text of the Law for the Equality of Women and Men and Lives Free of Sexist Violence against Women (BOE, 2023)[23], that obstetric violence constitutes a form of gender-based violence against women.

However, this is not enough, because – returning to the topic of broadness mentioned when talking about the limitations of the international legal framework – exclusively mentioning obstetric violence without defining it, leaves too much room for interpretation and can therefore contribute to considering obstetric violence only the extremely harmful and damaging instances suffered by women in which quantifiable damage exists, leaving all other instances that also do constitute obstetric violence unattended.

Nonetheless, the fact that these three autonomous communities have explicitly included obstetric violence should serve as an inspiration, especially in the case of Catalonia, for the rest of autonomous regions to follow suit, and not only include the term, but also define it extensively, with the help of associations and experts in obstetric violence.

7.2.3. Regulations on violence against women and gender discrimination.

The 14th article of the Spanish Constitution (BOE, 1978)[24] proclaims that no discrimination based on birth, race, sex, religion, opinion or any other condition or personal or social circumstance shall prevail.

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[22] Ley 10/2014, de 29 de diciembre, de Salud de la Comunitat Valenciana. Published in: BOE núm. 35, de 10 de febrero de 2015.
[23] Decreto Legislativo 1/2023, de 16 de marzo, por el que se aprueba el texto refundido de la Ley para la Igualdad de Mujeres y Hombres y Vidas Libres de Violencia Machista contra las Mujeres. Published in: BOE núm. 89, de 14 de abril de 2023.
[24] Constitución Española. Published in: BOE núm. 311, de 29 de diciembre de 1978.

On the other hand, the Organic Law 1/2004, of December 28, on Integral Protection Measures against Gender-based Violence defines gender-based violence (BOE, 2004)[25] in its 1st article as:

> "a manifestation of the discrimination, the situation of inequality and the power relations of men over women, is exercised over them by those who are or have been their spouses or of those who are or have been linked to them by similar affective relationships, even without coexistence [...] includes all acts of physical and psychological violence, including attacks on sexual freedom, threats, coercion or arbitrary deprivation of liberty".

This definition however falls short, since it refers to those instances in which violence against women is exerted by men that have been in a affective relationship with them and cannot be applicable to instances in which gender-based violence is exerted by people in other contexts, such as healthcare and is therefore not applicable to instances of obstetric violence.

Aside from Organic Law 1/2004, there is no other law that specifically regulates violence against women in other settings other than affective relationships, and while violence in affective relationships is unfortunately prevalent, legislation on violence against women cannot be reduced solely to that.

Other than that, Spain's Organic Law 3/2007, of March 22, for the effective equality of women and men (BOE, 2007)[26] which aims to promote gender equality must be mentioned. Its 3rd article declares that "the principle of equal treatment between women and men implies the absence of any discrimination, direct or indirect, due to sex, and, especially, those derived from motherhood, the assumption of family obligations and marital status".

Additionally, its 6th article differentiates between direct and indirect discrimination on grounds of sex. Direct discrimination on grounds of sex is the

[25] Ley Orgánica 1/2004, de 28 de diciembre, de Medidas de Protección Integral contra la Violencia de Género. Published in: BOE núm. 313, de 29 de diciembre de 2004.
[26] Ley Orgánica 3/2007, de 22 de marzo, para la igualdad efectiva de mujeres y hombres. Published in: BOE núm. 71, de 23 de marzo de 2007.

situation of a person that, because of their sex, is, has been or could be treated in a less favorable way than another person in a comparable situation, while indirect discrimination is considered when a apparently neutral criteria or practice is discriminatory towards a sex in particular in comparison to the other sex, unless it can be proven that those measures are objectively justified in order to fulfill a legitimate goal. It concludes by stating that any order to discriminate, direct or indirect, is considered discriminatory on the basis of sex.

It could be argued that the wording of this law is obsolete, since it refers to discrimination solely based on sex, when a more appropriate approach would be sex and gender – see section 4.1 –.

It is its 8th article that is more relevant to obstetric violence, since it states that any unfavorable treatment of women related to pregnancy or motherhood constitutes direct discrimination based on sex. It is safe to conclude that obstetric violence constitutes unfavorable treatment of women related to pregnancy and motherhood and thus, direct discrimination, which will result, according to the law's 10th article, in "liability through a system of reparations or compensations that are real, effective and proportionate to the damage suffered, as well as, where appropriate, through an effective and dissuasive system of sanctions to prevent discriminatory conducts from being carried out".

However, as we have seen via the three resolutions of the Committee that declare Spain guilty of perpetuating obstetric violence, and the research and reports that have shown that almost 40% of women believe they have suffered obstetric violence – see section 5.2. – it can be safely deduced that what Law 3/2007 declares is not being fulfilled by the state.

In addition to all of this, it might be interesting to note that the Penal Code (BOE, 1995)[27] claims in its 174th article that "the authority or public official who, abusing his position, [...] for any reason based on any type of discrimination, subjects a person to conditions or procedures that cause physical or mental harm, the suppression

[27] Ley Orgánica 10/1995, de 23 de noviembre, del Código Penal. Published in: BOE núm. 281, de 24 de noviembre de 1995.

or diminution of their powers of knowledge, discernment or decision or that, in any other way, violate their moral integrity" is committing torture and is punished with prison sentences ranging from one year to six years, depending on the gravity of the each particular instance.

Additionally, its 511th article claims that "the particular individual in charge of a public service who denies a person a provision to which he is entitled to because of his ideology, religion or beliefs, family situation, ethnic, racial or national origin, sex, age, sexual or gender orientation or identity, gender, aporophobia or social exclusion, illness or disability" will also be punished with a prison sentence, a fine ranging from twelve to twenty-four months and special disqualification for employment or public office for a period of one to three years.

A priori, it would be reasonable to think that both these articles would be applicable in some obstetric violence cases. Concerning article 174 and as the Special Rapporteur stated in her report, obstetric violence could amount to torture in some cases (UNHRC, 2019). Concerning article 511 and as stated before on this paper, obstetric violence is not only the performance of unwanted procedures, but also the denial of wanted ones.

However, there is nuance to both these articles that must be explained in order to understand why they cannot be currently applied to obstetric violence. Both of these articles require, among other things, willful intent, that is, the premeditated intention of, in this case, either torturing or denying services to a woman with the sole reason being her gender. As we have explained before, obstetric violence is not the individual action of a particular healthcare but a consequence of a structural and institutional problem. That is to say, while healthcare professionals may exhibit behaviors that are distasteful, offensive and/or hurtful they generally do not have the intent to discriminate against women explicitly because of their gender.

In this case, both of these articles require the perpetrator to actively and consciously have the intent and objective of discriminating against a patient because she is a woman. This cannot be said about the vast majority of healthcare professionals because their actions are a consequence of the deeply internalized sex/gender system, so

although their actions have a sexist origin, there is no willful intent of specifically hurting a woman because of her gender. These articles could, in theory and in extremely select cases, be applicable, however, it is the difficulty to prove that a healthcare professional acted solely with the intent to discriminate that makes these articles – almost – impossible to apply to obstetric violence cases.

In a similar manner, article 10.1 of the Law 14/1986, of April 25, General of Health (BOE, 1986)[28], recognizes as a right "the respect of their personality, human dignity and privacy, without it being discriminated against due to racial or ethnic origin, gender and sexual orientation, disability or any other personal or social circumstance" .

Organic Laws 10/2022, of September 6, on Integral Guarantee of Sexual Freedom (BOE, 2022)[29], and 1/2023, of February 28, which modifies Organic Law 2/2010, of March 3rd, on Sexual and Reproductive Health and Voluntary Interruption of Pregnancy (BOE, 2023) are also worth mentioning.

Some – like Martínez (2023) – consider Organic Law 1/2023 to be Spain's response to the Committee's recommendations regarding its obstetric violence cases. This law aims to guarantee fundamental rights in the context of sexual and reproductive health and to prevent violence against women in the reproductive field. This violence is defined in the second section of its only article as "any act based in discrimination based on gender that threatens the integrity or free choice of women in the field of sexual and reproductive health, their free decision about motherhood, its spacing and opportunity".

It explains in its public policies section, in the sixth section of article 1, that "public powers, in the development of their health policies, educational and professional training, and social will guarantee: [...] h) The prevention, punishment and eradication of any form of violence against women in relation to health, sexual and reproductive rights".

[28] Ley 14/1986, de 25 de abril, General de Sanidad. Published in: BOE núm. 102, de 29 de abril de 1986.
[29] Ley Orgánica 10/2022, de 6 de septiembre, de garantía integral de la libertad sexual. Published in: BOE núm. 215, de 07 de septiembre de 2022.

This should be applicable to obstetric violence, since obstetric violence, by definition, constitutes a violation of women's health, sexual and reproductive rights. However, it still proves very difficult for obstetric violence to be recognized as such violation, largely, due to it not being recognized legally.

Finally, this law proposes the creation of a State Strategy for Sexual and Reproductive Health and further research and data collection and production as measures for the effective compliance with this law. On this note, it must be remembered that a Strategy for Assistance at Normal Childbirth in the National Health System has existed since 2007, developed by the Ministry of Health and Consumers' Affairs, "with the objective of improving the quality of health care in assistance at childbirth in all parts of the territory, and so contribute to the cohesion which our Health System requires in order to benefit all citizens equally" (Ministry of Health, n.d.).

7.2.4. Regulations on informed consent.

Previously mentioned before Law 14/1986, of April 25, General of Health (BOE, 1986) recognizes the information about the health services one can access as a right. However, on informed consent, the Law 41/2002, of November 14, basic regulatory of autonomy of the patient and rights and obligations regarding information and clinical documentation (BOE, 2002)[30], is the most notorious.

Its 3rd article defines informed consent as "the free, voluntary and conscious compliance of a patient, manifested in the full use of his powers after receiving adequate information, for an action to take place that affects their health" and states in its 4th article the right of patients to know all information available regarding all areas of their health, with the exemptions the law makes, that the doctor responsible for the patient will guarantee this right to information and that the professionals who assist during the care process or apply a specific technique or procedure will be responsible of also providing that information.

[30] Ley 41/2002, de 14 de noviembre, básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica. Published in: BOE núm. 274, de 15 de noviembre de 2002.

In its 10th article, this law states how informed consent should be sought:

> "1. The physician will provide the patient, before obtaining written consent, with the following basic information:
>
> a) The relevant or important consequences that the intervention causes with security.
> b) Risks related to the personal or professional circumstances of the patient.
> c) The probable risks under normal conditions, according to experience and the state of science or directly related to the type of intervention.
> d) Contraindications.
>
> 2. The responsible doctor must consider in each case that the more doubtful the result of an intervention the more necessary is the prior written consent of the patient".

In terms of obstetric violence, this is the most referred to law as in the vast majority of cases, healthcare professionals do not seek informed consent from women. Because of the urgent nature of birth, healthcare professionals do not feel the need to properly inform and seek consent, justifying it by alleging medical necessity and urgency.

However, even if a woman is able to prove that informed consent was not sought, which has proven to be difficult enough as it is, the compensation and justice provided would not cover all damage done by the obstetric suffered, and would only cover a small part of the regrettable experience.

Another reason for this law being brought up and used when denouncing obstetric violence is that women simply do not have any other available and effective ways of claiming state liability. Resources for indemnifying victims of obstetric violence are conspicuous by its absence, leading them to try and get justice by all means available and necessary.

Having all of this in mind, it can be concluded that Spain's current regulation is ineffective and insufficient, thus making specific regulation on obstetric violence

necessary, while still acknowledging that steps are being taken in the right direction, especially since obstetric violence is, slowly but surely, increasingly being highlighted.

8. CONCLUSIONS AND PROPOSALS.

Obstetric violence involves such damage, that having suffered it in pregnancy and/or childbirth, it doesn't end in postpartum. It's a type of violence that, even when they have given birth and left the hospital, haunts the women who have suffered it in several different forms, whether it is in the way of physical or psychological aftermath. It shatters the ideal of a positive childbirth experience and constitutes a violation of women's human rights.

This violence, that manifests itself mainly through unwanted medical interventions or the denial to perform wanted interventions, the lack of the necessary and adequate informed consent and degrading and disrespectful communication, among many other things, is the result of the beliefs and behaviors that not only healthcare professionals but also society has internalized.

It's important to note that, while it's true that in the vast majority of cases the direct victims are the mother and her child, they are usually not the only ones. The effects of obstetric violence, in many instances, reaches the mother's partner, and even the rest of the family.

The research and analysis done on this work has allowed me the opportunity to better understand the status quo of obstetric violence, and has therefore led me to make some conclusions and proposals.

Firstly, I was able to conclude that obstetric violence is yet another form of gender-based violence against women, which is, at the same time, one of the many consequences of the sex/gender system. Women are discriminated against, hurt and devalued on the basis of their gender – primarily, but not exclusively –, and this discrimination is so deeply rooted in all societies worldwide that it requires a collective effort to eliminate it.

Secondly, this discrimination is not merely mistreatment, but it also constitutes a human rights issue, as obstetric violence's impact extends to the point of violating women's human rights, not only as women, but also as people and subjects of law. This relentless violation of human rights should make alarms go off, but for some reason – probably the fact that the people subjected to these violations are women, and are also silenced –, it does not.

In third place, obstetric violence and its devastating consequences are not a priority in today's feminist or political agenda, a fact that, although unfortunate, cannot come off as surprising. This is because of the under-recognition of obstetric violence, which is a direct consequence of the medical community's strong resistance to the term obstetric violence and subsequent denial that women are discriminated against and mistreated in healthcare settings.

As an example, the Resolution 2306 adopted by the Parliamentary Assembly of the Council of Europe (2019, p. 2) states that "the prevention of and fight against gynaecological and obstetrical violence are not yet considered priorities". How can the mistreatment and violation of human rights of hundreds of thousands of women around the world in what is probably one of the most common and frequent processes of human nature not be a priority?

In relation to the prior conclusion, the lack of regulation on this issue renders the victims helpless. A reason for this is that, as mentioned before, the irrelevance of the matter in the public and political agenda derives in the belief that there is no urgent need – if at all – of regulating it. Another reason is the medical community's – which resists and denies the existence of obstetric violence – undeniable influence on the states' lawmakers, which consequently results in not recognizing obstetric violence and regulating it legally.

Lastly, and as seen throughout this work, the current state of the laws and regulations is not effective in this matter, which makes allowing victims of this violence to claim compensation and seek justice close to impossible. Women have very little legal options to denounce the mistreatment and injuries suffered, and when trying to do

so – with the emotional and economic cost it entails –, it results in the judicial power dismissing those claims.

As observed in the many statements that medical institutions have released, the medical community prides itself in the excellence of their work and the care they provide, but is it possible to talk about excellence when so many women are not safe when having a child? Isn't the mistreatment women face in this context unjust? Even more so, isn't the constant denial that this mistreatment even exists also unjust?

In order to address some of the concerns manifested in this paper, I have included some proposals:

I believe more education is required when talking about obstetric violence, not only in terms of the healthcare professionals and lawmakers, but also the general public. When it comes to the latter, public campaigns could be a good option in order to help bring awareness to the problem, and also help mothers who, having suffered obstetric violence, have not been able to identify it as such. A good start could be running advertisements on television – as done with other issues, such as gambling – and posting about it on the state's official social media accounts, as they have immense reach.

Seeing as how things are, the medical community could also benefit from more insight that could be provided via the participation of women who have suffered from obstetric violence or any kind of mistreatment in obstetric care. Involucrating both sides could be very beneficial in helping prevent future mistreatment. However, another very important element should be taken into account, and that is helping healthcare professionals understand that recognizing obstetric violence does not intend to place the blame on them individually, nor would it undermine their calling to help others, but instead, it would allow us to recognize the cruel role that the sex/gender system has and how it reflects in the way our society is designed and made up, and it would help eradicate the subsequent discrimination and damage it entails. I believe understanding this would make their response to obstetric violence being recognized less defensive, and would allow them to make space for constructive criticism and change.

It is also important to complement this education with the development of medical protocols with the sole purpose of conceptualizing and preventing obstetric violence. There should be a list of actions that are classified as manifestations of obstetric violences, enumerating not only the unwanted or the denial of wanted procedures, but also emphasizing the dismissive, patronizing and infantilizing communication style, along with underlining the importance of properly seeking informed consent, as the latter two tend to be very overlooked in obstetric care.

Moreover, continuous professional training on this subject should be provided, from an intersectional perspective, in which birthing should be viewed as a very intimate and important process that should be respected, understanding that this process varies from woman to woman, and that it is not a process that should accommodate the will and wants of the healthcare system.

These measures would allow for obstetric violence to gain visibility and relevance, and thus, would be placed higher in public and political agendas. This would result in increasing pressure for lawmakers to legally recognize obstetric violence. Nonetheless, their action cannot stop at merely recognizing obstetric violence – which is difficult as it is –, but they must also further develop legislation in terms of: one the one hand, especially protecting women's rights during pregnancy, partum and postpartum, not solely as a means of reproduction, but as vulnerable group of people in an especially vulnerable situation; on the other hand, designing regulations to prevent this problem from occurring as much as possible; and lastly, providing effective and accessible ways of legally seeking justice and compensation from the state, even when there is no apparent quantifiable damage, as the damages suffered are not always quantifiable as per the state's scales.

Aside from this, informed consent, when sought appropriately, does not only benefit patients, but also healthcare professionals, ethically and legally speaking. While I am able to appreciate the particular urgency of labor, informing and seeking consent from the patients leads to them being more at ease, as they feel heard, able to be autonomous and understand the decisions they are making regarding themselves and their babies, which increases the sense of trust towards the healthcare professionals, consequently reflecting in a less tense and aggressive atmosphere.

This would benefit healthcare professionals in knowing that the procedures being done are consented, understood and wanted by the patients, allowing them to perform those procedures with a clear conscience. In terms of legality, this would also benefit healthcare professionals as a valid informed consent would legally protect them, as the consent was given with full information and capacity. Thus, informed consent should not be approached merely as a paper that must be signed, but as a conversation between the patient and the healthcare professional in which information is provided, and that allows both of them to express their opinions and concerns, subsequently reaching an agreement together.

These recommendations can all be applied to Spain's way of handling – or the lack of handling – obstetric violences as an issue that affects a very considerable amount of its population. As stated before, education must be provided for healthcare professionals and the general public, and lawmakers must cooperate and legislate about obstetric violence. While I do believe that with current legislation informed consent is addressed enough, Spanish lawmakers should focus on recognizing and legislating explicitly on obstetric violence – highlighting once again the importance of informed consent –, which would significantly improve the satisfaction rate among both patients and healthcare workers, and help contribute to a less discriminatory society and legislation. As notorious international organizations such as the World Health Organization and United Nations have stated, it is necessary to aim for the highest possible standard for care (WHO, 1946; UN, 1993), especially when it comes to pregnant women, and therefore, Spain has a obligation towards its population to properly proved, promote and protect such a basic human right like the right to health.

It is a generally known fact that lawmaking has always followed reality belatedly, however, this issue is not new and so I believe enough time has passed. It is necessary to admit an issue exists in order to handle it, given that the lack of regulation does not only discourage women from denouncing obstetric violence but also hinders their ability of recognizing it as such. Ideally, the idea would not be to punish obstetric violence and make an already punitive system, even more punitive, but to legislate in a manner that obstetric violence is so reduced it becomes an anomaly, not the norm.

9. ANNEXES.

ANNEX I: INTERVIEW SCRIPT.

Introduction:
I introduce myself, explain the purpose of the interview, ask if I can record the interview for the sole purpose of referring to it for this work and if she wants to appear anonymous. I remind her that we are going to revisit her experience and that if she feels uncomfortable or does not want to answer a question, that is okay.

Section ONE: Pregnancy.

- Ask about what her experience was like during pregnancy: positive or negative, what stood out, especially in terms of medical care.
    - Refer to this later on, to ask if she considers that she suffered any act of violence during pregnancy or if that did not occur until she arrived at the hospital to give birth.
    - Ask if she considers that she was given information regarding the birth or if she "went in blind", about how her birth was supposed to be like or what she could expect, how much attention they were going to pay to her birth plan…
    - Ask about which aspects of the care received she considers could be improved.
- Ask if there was a reason she chose to give birth in the hospital instead of in her home.
- What was the process of decision-making and carrying out the birth plan, and the expectations that this entailed taking into account that this was her first child.
    - If she knew about other women's experiences and if this affected her when deciding how she wanted her birth to be.
        - Did she know about obstetric violence or know about experiences similar to it?

Section TWO: Birth.

- Upon her arrival at the hospital, a healthcare professional performs a digital vaginal exam to check whether or not her sac "really" broke. How did that make her feel? What were her first impressions? Did expectations change upon that encounter regarding the birth she was going to have?
- Resident students appear, was she informed beforehand? Was she given some kind of alternative?
- Was she given any document informing her about any intervention or procedure for her to sign?
    - Did she sign anything without really understanding what it was?

    - Was she given anything to sign at all? Is there any written record of the interventions and procedures carried out?
- Does medical discretionality and/or medical necessity prevail over other commitments to the patients? Is she in favor or against this?
    - In her particular case, does she consider that medical discretionality and/or necessity prevailed over her needs?
- How did she feel at this point? Did she realize there was a problem or did she consider she was having bad luck in regards to the care she was receiving?
- Did she feel a disparity between the care provided by male healthcare professionals and female healthcare professionals?
- If she realized the difference at that moment, did it lead her to try to seek refuge or lean on them, if she felt more listened to, understood… by female healthcare professionals.
    - Based on this, does she consider her experience would have been different if only women had provided the care for her?
    - If she realized the difference later, what led her to conclude that?
    - If she did not notice a difference, does she consider that healthcare professionals, regardless of their gender, act in the same way due to their position of power.
- Does she consider the treatment of infantilization or dehumanization, lack of emotional support, a deliberate attempt on the part of the healthcare professionals to try to inhibit her and subject her to a more submissive state of mind?
    - Or if, on the contrary, she believes they have this behavior so internalized they are not aware of it?
- Did the difference in the power hierarchy intimidated her into not making requests, questions, etc...?

Section THREE: Postpartum.

- What was the postpartum like once she had her baby and was with her partner? How did her partner experience it?
- Did she have any knowledge about the hospital's protocol?
    - Was it mentioned to her when she was pregnant, during birth or even afterwards? Was it even mentioned at all?
- In her case, when told that labor had to be induced, was she aware that as per the hospital's protocol there was a twenty-four hour waiting period?
    - If not, would knowing about it have changed her experience?
    - If yes, was she aware it was not being fulfilled?
- In which ways does she believe her and her baby were put at risk?
- After giving birth, what was the process until realizing that her experience constituted a case of obstetric violence?
    - Was there a specific trigger?
    - Was it the accumulation of everything?

    - Was it when talking to her partner, with a healthcare worker, with the health center staff, with family members, other women? Did she realize it by herself?
- Did she know about obstetric violence beforehand?
    - How did she get to know it?
    - How did she inform herself?
- What is obstetric violence in her opinion?
    - Does it relate to gender-based violence against women?
    - Does she consider that being a woman affected her experience? Would it be different if men were the ones to give birth?
    - How does she believe her experience reflected societal views on women's bodies and decision-making in healthcare settings?
- Based on the fact that she was not adequately and sufficiently informed about the interventions that were going to be carried out:
    - How would knowing about other possible alternatives have changed her experience?
    - Would she have had more security on herself if she had been informed?
    - Would her partner have been able to intervene for her?
- Did she give informed consent (if she did at all) to interventions that she would have not consented if she had been properly informed?
    - Does she believe that, in the case of wanting to withdraw consent, it would have been allowed?
    - If asked to consent, was she informed about risks, alternatives…
- Was informed consent sought verbally or written?
    - In her opinion, how should informed consent be sought?
        - Written, verbally, other requisites…

Section FOUR: Legal.

- How was the process from the postpartum to filing the first claim/complaint? What did that result in?
- After so many legal processes and time, who or what did she rely on to keep her going?
- Are current state regulations enough to claim liability from the state or healthcare workers?
- Did she feel protected by the existing legal framework?
- Which does she think are the possibilities for a woman who has suffered obstetric violence has to denounce it?
    - Is it enough?
    - Should regulations be expanded on this matter?
    - Does she consider that since it is a type of violence that is not even recognized, women are discouraged from taking judicial or extrajudicial measures?

- Seeing the state's response starting from the very first claim up until the CEDAW's resolution, does she feel compensated? Was it worth it? What does she think of the response given by both the state and the hospital?
- How has this experience as a whole affected her in the way she interacts in healthcare settings or with professionals?

Conclude, ask if there is anything she wants to add or want to state for the record, thank her for her time and participation.

ANNEX II: NAHIA'S BIRTH PLAN.
Translated from: Nahia Alkorta's "Mi parto robado" (2023), pp. 57-59.

"Nahia Alkorta's Birth Plan.

Mother: Nahia Alkorta Elezgarai.
Father: Aitor.
Child: Mikel (will be born around July 22nd).

Through this birth plan we want to express that we want Mikel's birth and his first days of life to occur in the most natural way possible and with the least possible intervention.

Even so, we are aware that if any complications were to occur, our wishes may be impossible to fulfill and we ask that all necessary medical interventions be carried out after consulting us.

- We want Aitor, Mikel's father, to accompany and help Nahia through labor and hospitalization, even if there was a need for instrumentalization.
- We do not want medications to be administered to provoke or accelerate labor.
- In principle, I do not want epidural analgesia. To control the pain, I prefer to use the bathtub, ball, massages, breathing exercises or other resources offered by the hospital.
- We want to have as little intervention as possible, we would appreciate it if there were as few personnel as possible throughout the process.
- I want it to be me, Nahia, who chooses the best posture to birth Mikel.
- We want the decisions that the medical staff has to make to be consulted and agreed upon with us (even if episiotomy or another process were necessary).
- If a cesarean section is necessary, I want to see Mikel as soon as he is born, and if I were to come out later of the operating room, we want Mikel to be with Aitor.

- We want the umbilical cord to not be cut as long as it continues to beat, and we would like XXX to be the one to cut it.
- We want Mikel to be placed in Nahia's belly when he is born.
- We will appreciate help with natural breastfeeding, and that is why we ask that Mikel not be offered bottles or pacifiers, nor that perfume be applied to him.
- The tests that are done at birth, if it is not totally necessary to do them at that time, we prefer that they be done later or on the belly.
- We want to thank you in advance for accompanying us in such a special moment for us.

Sincerely,”

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