

Gynaecological & obstetric violence



The conceptualisation and legal codification of gynaecological and obstetric violence as a form of gender-based violence and as a criminal offence was the result of pioneering work in Venezuela¹, Argentina², and in many other Latin American countries³ over 15 years ago.

The widespread and systemic mistreatment and violence against women experienced during childbirth and other reproductive health services has since then gained international recognition. In 2014, the [World Health Organisation](#) (WHO) acknowledged that “across the world many women experience disrespectful, abusive, or neglectful treatment during childbirth in facilities”. In 2019, the UN Special Rapporteur on Violence against Women characterised mistreatment and violence against women in reproductive health services as “a serious violation of women’s human rights occurring across all geographical and income-level settings”, in her dedicated [report](#) on the topic.

Although action has been taken by governments across Latin America and the UN, in Europe, the interest for, and recognition of, this type of violence has

been only growing since 2017–2018, and **has just been on the agenda** of decision-makers over the last couple of years. Both parliaments of the two European inter-governmental institutions, the [Council of Europe](#)⁴ and [European Union](#), very recently adopted resolutions drawing attention to this phenomenon and calling for measures to address it, at a national and European level. However, much progress remains to be done to document and tackle it. **No European country has so far put in place legislation specifically criminalising this form of violence**⁵.

This paper aims to provide a brief outline of the systemic and widespread nature of gynaecological and obstetric violence across many countries in Europe, and to make recommendations to European and national decision-makers to tackle this form of violence.

Gynaecological and obstetric violence – Definition

Gynaecological and obstetric violence refers to a type of violence at the intersection of **gender-based violence** (meaning targeting women just because they are women⁶) and **institutional violence** (rooted in structural power imbalances within established institutions), taking place in healthcare settings during gynaecological or obstetric consultations.

It implies “the appropriation of women’s bodies and reproductive processes by health personnel, which is embodied in a dehumanising treatment, in abuses of medicalisation and pathologizing of natural processes, thus causing loss of autonomy and of free decision-making on a woman’s own body and sexuality, negatively influencing women’s quality of life”, as detailed by the Venezuelan law.

Gynaecological and obstetric violence is an umbrella term that encompasses **a variety of demeaning, violent, and harmful practices**⁷, perpetrated during all types of gynaecological and obstetric care. As such, it can happen **throughout the lifecycle**⁸, when seeking gynaecological examinations, access to contraception, fertility treatments, abortion care, after miscarriages, during pregnancy, and during and after childbirth.

The root causes of gynaecological and obstetric violence

Gynaecological and obstetric violence is a form of **gender-based violence**: The discriminatory treatment of women in healthcare settings is deeply rooted in gender, social and cultural norms, which perpetuate a cycle of structural inequality, dictated by patriarchal and male-dominated societies and health systems.

Multiple and intersecting forms of discrimination play a significant role in amplifying gynaecological and obstetric violence: Women from certain groups (e.g. Roma women, women of colour, women living with a disability, incarcerated women⁹, LGBTIQ+ women, women in a low socioeconomic or educational status etc.), are particularly at risk.

LBTIQ+ women are vulnerable to mistreatment when seeking medical treatment, facing prejudice on the basis of actual or perceived non-conformity with socially determined gender roles.

Many studies show that racism increases the likelihood of women of colour, with a migrant background or belonging to ethnic minorities, of experiencing such violence: in [Belgium](#) 1 out of 3 women of colour experienced some form of obstetric violence (compared to the general average of 1 in 5); in [Greece](#) evidence shows that women living in refugee camps face high levels of disrespect in obstetric care, including over 60% being subjected to routine Caesarean section and a total lack of informed consent to any medical act during labour; in [Ireland](#), Traveller women testified to have experienced racism, neglect, delayed treatment and abuse in maternity facilities. Roma women in [Slovakia](#) are placed in Roma-only wards, which tend to be overcrowded, poorly sanitised and women are often forced to sleep two to a bed or in a corridor. They are also frequently subjected to forced sterilisation policies (see below). In some cases, their consent is coerced, through forcing them to sign forms they do not understand or without prior information provided.

Moreover, even socio-economic and educational status can influence the level of violence suffered. In [Belgium](#), for instance, 1 in 4 women with a lower level of studies are survivors of obstetric violence, a higher percentage than the average.

Gynaecological and obstetric violence is enabled by a power imbalance between doctors and their patients, which contributes to a culture of human rights violations. “Power dynamics in the provider-patient relationship are another root cause of mistreatment and violence, which are compounded with gender stereotypes on the role of women. The health provider has the power of authoritative medical knowledge and the social privilege of medical authority¹¹.” An international study in the British journal [BMC Pregnancy Childbirth](#) found that 66.7% of the women who described a traumatic birth found the “care provider actions and interactions as the traumatic element” in their childbirth experience.

A lack of effective complaint and accountability mechanisms contributes to maintaining this power imbalance in place. When reporting mechanisms do exist, they may lack in impartiality, as complaints are often examined by healthcare professionals themselves, and end up being dismissed.

A lack of awareness and empowerment of patients often leads them to accept unacceptable situations, out of insufficient knowledge of what constitutes quality provision of healthcare¹², a lack of awareness of their rights when accessing healthcare services, and the normalisation of such violence. According to a report from [Belgium](#), 95% of women who were subjected to violence were not aware they had been violated.

Only recently have women started to speak about being mistreated by healthcare workers. Online platforms have sparked campaigns and enabled women to share their experiences. In Europe, testimonies¹³ show that mistreatment and violence is widespread.

The types of gynaecological and obstetric violence

Gynaecological and obstetric violence can take many forms, which are not mutually exclusive:

Psychological, physical and/or sexual violence in the context of gynaecological and obstetric consultations: this includes humiliation, verbal abuse, sexist remarks, lack of respect for privacy and confidentiality, as well as physical abuse (slapping, pushing), and non-consensual vaginal/rectal penetration or touching for medical examinations.

Forced/non-consensual medical acts: these include all type of medical (whether necessary or unnecessary) acts carried out without free, prior, and informed consent from the patient.

Routine and/or non-medically necessary harmful procedures: this comprehends all procedures that do not comply with clinical guidelines (particularly those issued by WHO), which are carried out due to harmful gender and social norms, or for the convenience of healthcare professionals.

Delay or refusal of care: this includes delay or refusal to administer pain management medication during painful gynaecological or obstetric interventions. It also encompasses delay or refusal to provide abortion care.

The specific forms of gynaecological and obstetric violence

Within the aforementioned four macro-categories, the following specific behaviours, medical acts or procedures can be listed. This does not aim to be an exhaustive list but to show the wide range of practices that gynaecological and obstetric violence entails.

A. NON-CONSENSUAL INTERNAL (VAGINAL OR RECTAL) EXAMINATIONS

Vaginal examinations are generally regarded as a routine procedure during gynaecological consultations and childbirth. When forced or conducted without consent however, they may constitute sexual violence¹⁴. In France, in September 2021 and May 2022, two former gynaecologists working at the same hospital in Paris have been accused by several women of allegedly undertaking forced rectal and vaginal penetrations during examinations without the patient's consent or openly against her refusal, which is currently being [investigated](#) as rape.

B. FORCED CONTRACEPTION, FORCED STERILISATION, FORCED ABORTION

Forced contraception, forced sterilisation, forced abortion – carried out without informed consent, are tools for social and population control, particularly directed at marginalised groups, such as women belonging to ethnic minorities (including Roma women), those living with disabilities, with HIV, transgender and intersex persons, etc. UN experts and bodies have affirmed that forced sterilization or forced contraception [infringe](#) upon “the right of women to decide on the number and spacing of their children and adversely affects women’s physical and mental health”, and have called on States to prohibit “all forms of forced sterilization, forced abortion and non-consensual birth control”. Forced sterilisation and forced abortion are explicitly prohibited by the [Istanbul Convention](#) (Article 39).

- **Forced sterilisation:** Forced, coercive or otherwise involuntary [sterilisation](#) is a form of gender-based violence that violates a person’s right to be [free from torture](#) and ill-treatment. It is notably [committed](#) against ethnic minority and indigenous women. Cases of involuntary sterilisation of Roma women have been carried out under the communist regime in Czechoslovakia since the early 1970s. In [V.C. v. Slovakia](#), the European Court of Human Rights found that this amounted to inhumane and degrading treatment. Coerced sterilisation is also legally imposed on transgender people as a condition to access legal gender recognition, in several EU Member States, a practice condemned by the [UN Special Rapporteur on torture](#).
- **Forced contraception:** Girls and women with disabilities are often [coerced](#) into taking contraception. A [report](#) looks at Spain, where this practice is ongoing, and recent cases in France and Croatia. [The UN Convention on the Rights of Persons with Disabilities](#) (CRPD) underlines the right of persons with disabilities to found a family and to retain their fertility on an equal basis with others.
- **Forced abortion:** The [Special Rapporteur on the rights of persons with disabilities](#) highlighted that “girls and young women with disabilities are frequently pressured to end their pregnancies” and called to ensure their right to free and informed consent is protected.

C. MISTREATMENTS DURING ABORTION CARE

According to WHO latest [Guidelines](#) (2022), comprehensive abortion care (related to both voluntary termination of pregnancy and to pregnancy loss) must be safe, timely, affordable, non-discriminatory and respectful, and must be supported by an enabling environment based on human rights, provision of correct information and a supportive health system.

Nevertheless, in many countries, women and girls may face mistreatments when accessing legal abortion services, as acknowledged by the UN [Special Rapporteur on Torture](#)¹⁵. Mistreatments in abortion care are compounded by cultural beliefs, stigma, and stereotypes about abortion and those who have them¹⁶. They are often perpetrated by anti-choice healthcare professionals, who oppose the right to abortion or hold stigmatising views on abortion, as a way of [punishing](#) and controlling women who choose an abortion¹⁷. Mistreatments during abortion care should be tackled as a priority within the framework of gynaecological and obstetric violence, alongside violence during all other sexual and reproductive healthcare consultations.

In France, testimonies were highlighted in a [report](#) of healthcare professionals trying to dissuade women from getting an abortion, forcing them to listen to the ‘foetal heartbeat’, and refusing them painkillers to ‘teach them a lesson’.

In Poland, in the case of [R.R. v. Poland](#), doctors delayed access to a genetic examination to confirm a potential foetal malformation, until it was too late for the woman concerned to legally access abortion care in Poland. In [P and S v. Poland](#)¹⁸, a minor victim of rape suffered a series of mistreatments, stigmatising, and shaming psychological abuse, in an attempt to convince her to carry the pregnancy to term and to deny her access to care she crucially needed, although she was legally entitled to it. In both cases, the European Court of Human Rights found the claimants had been subjected to degrading and inhumane treatment under Article 3 of the European Convention of Human Rights.¹⁹

In [Croatia](#), the testimony of MP Ivana Ninčević-Lesandrić in October 2018 around [her painful experience](#) of an invasive procedure after a miscarriage carried out without anaesthesia in a Croatian hospital sparked the campaign [#prekinimošutnju](#) (“#BreakTheSilence”), launched by the NGO Roda, in which hundreds of women shared similar experiences. Following a month of public [debate, complaints](#) were sent to UN bodies on obstetric violence in Croatia and a [statement](#) was issued by UN experts calling on the government “to conduct an independent investigation into those allegations, to publish its results and to elaborate a national action plan for women’s health.”

D. VIOLENCE DURING PREGNANCY AND CHILDBIRTH

The area where most evidence of violence has been collected is probably around childbirth, spanning from psychological abuse, non-consensual, sometimes harmful, procedures, to undermining the dignity and integrity of women giving birth; in non-compliance with WHO recommendations on [antenatal](#) and [intrapartum care](#) for positive pregnancy and childbirth experiences. As for other types of gender-based violence, the COVID-19 pandemic exacerbated pre-existing structural issues in facility-based births. Between March 2020 and March 2021, a [study](#) on women who gave birth in 12 countries in Europe found that 23.9% felt they were not treated with dignity and 12.5% suffered abuse. In [Italy](#) and [Portugal](#), between 2020 and 2021, women who tested positive were prevented from skin-to-skin contact with their new-borns and from breastfeeding while in the hospital. Additionally, in [Belgium, Portugal, Ireland, France](#) and many other EU countries, partners or companions were prevented from attending prenatal appointments, during labour and birth, and postpartum. The absence of companionship during childbirth is [known](#) to be responsible for negative emotional birth experience, which can increase the risk of postpartum depression and post-traumatic stress disorder. In [Belgium](#), women were required to wear a mask while giving birth in 2020 and most of 2021, despite this not being recommended by international standards.

- **Psychological and physical abuse during antenatal care and childbirth.** A [study](#) carried out across six Northern European countries found that one in five pregnant women attending routine antenatal care reported some abuse in healthcare. A [study](#) undertaken in Germany and the Netherlands found 76.3% of women experienced obstetric violence during childbirth. A nationally representative survey conducted in

Italy in September 2017 [found](#) that the equivalent of one million women (21%) declared they suffered some form of obstetric violence during their first experience of childbirth. 4 mothers out of 10 affirm that they have been subjected to practices around delivery that undermined their personal dignity and integrity. In [Belgium](#) 1 out of 4 reported to have suffered psychological violence during childbirth. 6% of women [reported](#) having experienced verbal abuse and almost 3% experienced physical abuse such as being slapped or women being physically pushed during their delivery by the nursing staff.

- **Non-consensual medical acts during childbirth.** A study from [Finland](#) found that healthcare officials do not regard it as necessary or even possible to practice informed consent during childbirth. In a [sample](#) taken in Spain, 45.8% of women declared that healthcare professionals did not ask for their informed consent before every procedure and 38% perceived that they received unnecessary or potentially dangerous procedures during labour. The Spanish Observatory of Obstetric Violence conducting a [survey](#) of more than a 1000 women during childbirth, Caesarean section or abortion, found that over 50% of women were not informed of the intervention before it was performed, in 60.8% of cases, women were not given explanations or reasons for the procedures. In a qualitative analysis of over 600 testimonies undertaken in the Netherlands, over a quarter of participants described caregivers carrying out procedures such as internal examinations, episiotomies, or amniotomy without prior communication and in one third of these situations, women reported having said “no” explicitly either prior to the intervention, or asking the caregiver to stop during the intervention. This received little attention from national authorities or (disciplinary) courts, despite informed consent for medical procedures being a legal requirement.
- **Routine induction of labour.** Routine induction of labour is often not done for medical reasons or in the best interest of the woman, despite clear [WHO recommendations](#) on the subject, but instead for cost-effectiveness and to speed up the birthing process to fit hospital personnel shifts and with the view to freeing up maternity wards. During the COVID-19 pandemic, an increase of routine labour inductions was [observed](#) in Portuguese hospitals, with many women reporting being coerced into it. Moreover, in [Finland](#), 1 in 3 births are induced, with some hospitals reaching 45% of cases, which has become a common practice not linked to medical reasons and is almost always carried out without informed consent. In [Belgium](#), over 1 in 3 women had an oxytocin infusion to speed up their labour, which can have [harmful consequences](#) in terms of heightened risk of haemorrhages during the post-partum.
- **Routine Caesareans sections (C-sections).** Despite [WHO recommendations](#) to reduce unnecessary C-sections through non-clinical interventions, C-sections are [on the rise](#) in Europe. In [Cyprus](#), for instance, a study from 2021 showed that they now outnumber vaginal deliveries. C-sections are critical in situations where vaginal deliveries would pose risks. Yet, not all C-sections are medically justified, and unnecessary surgical procedures can be harmful, both for a woman and her baby, as indicated by WHO. As for the induction of labour, high numbers of C-sections can be connected with convenience of medical personnel and to fit hospital schedules. Some hospitals imposed C-sections on women who tested positive for COVID-19 in 2020 and 2021, which led to a rise in the number of non-medically necessary C-sections.

- **Fundal pressure.** Fundal pressure is the outdated technique of manually applying pressure or pushing downward at the top of the pregnant person's uterus. It is not beneficial and potentially harmful to women. Despite application of manual fundal pressure on women during vaginal birth not being recommended by [WHO](#), this is a widespread practice in health facilities. Fundal pressure can have major repercussions on women and new-borns' health, and its [consequences](#) include general bruising, abdominal bruising, fractured ribs, and even uterine tearing. The Council of Europe Commissioner for Human Rights has [condemned](#) its use. A [study](#) found fundal pressure was applied in 41.2% of births from March 2020 to March 2021 across 12 European countries and 76 studies from 22 countries [found](#) that 23.2% of women experience fundal pressure. The procedure is still [commonly used](#) in Europe. In [Spain](#), it is estimated that it is applied at a rate of around 25%. In [Belgium](#), 1 in 5 women has been subjected to fundal pressure.
- **Routine episiotomies.** An episiotomy is a deep cut in a woman's perineum into the pelvic floor muscle, designed to allow the new-born child to pass through more easily and prevent serious tears. This incision is not always necessary and is sometimes made merely to speed up delivery. Routine episiotomy is not recommended by the [WHO](#) unless in rare occasions if strictly medically necessary. The [UN Special Rapporteur on Violence against women](#) acknowledged that it "may have significant repercussions on a woman's reproductive and sexual life and mental health [...]. When not justified by medical necessity, it should be considered to be a violation of women's rights and a form of gender-based violence against women". Yet, a [study](#) carried out across 12 European countries from March 2020 to March 2021 found that episiotomies were performed in 20.1% of births. In [France](#), 1 out of 5 deliveries end up in episiotomies, with peaks of 45% in some hospitals, and in half of all cases, the hospital provides no explanation for doing so; in [Italy](#), 1 in 2 women suffers from routinely performed episiotomy, which is not consented to in one third of cases; in [Hungary](#) 7 out of 10 women experience it, and without their consent in over half of cases. Up to 89% of women underwent episiotomies in [Spain](#). Routine episiotomies have been compared to the harmful practice of [Female Genital Mutilation](#) (FGM), as their consequences over women's mental, physical, and sexual well-being can be similar to those of FGM. Episiotomies can notably harm the nerves of the inner parts of the clitoris. A policy of using episiotomy only when needed and not as a routine measure could result in [30% fewer women](#) experiencing severe perineal/vaginal trauma.
- **"Husband's stitch".** Another harmful practice happening in hospital settings after delivery, which is deeply rooted in patriarchal social structures, also compared by [expert organisations](#) to FGM, is the so-called "husband's stitch": stitching an episiotomy or the vaginal tear tighter, supposedly to increase the male partner's pleasure during sex. Women have testified of its negative consequences on their sexuality and are calling for it to be [abolished](#). The UN Special Rapporteur on Torture has also underscored the need for this practice to be eliminated. Even though there is lack of statistics and systematic studies around this phenomenon, anecdotal evidence and women's testimonies started emerging in recent years in some European countries (e.g. [France](#), [UK](#)). A study conducted in [Belgium](#) showed that around 6% of women suffered this sexist harmful practice, with peaks up to 13% in some hospitals.

Examples of best practices

Criminal law

Since 15 years, gynaecological and obstetric violence has been legally recognised as a criminal offence and a form of gender-based violence, in some Central and Latin American countries: [Venezuela](#) (2007), [Argentina](#) (2009), some States within [Mexico](#) (2007-2017) and [Brazil](#) (2017), and [Bolivia](#) (2019).

While many European countries legally require consent for medical acts in general, to date, **no European country has put in place criminal legislation** prohibiting gynaecological and obstetric violence as a specific form of violence²⁰.

Legislation

In Europe, only [Catalonia](#) (Spain) has adopted a law defining obstetric violence within its law on sexist violence²¹. This law includes: forced sterilisation, forced pregnancy, prevention of abortion in legally established cases and prevention to accessing contraceptive methods, as well as gynaecological and obstetric practices that do not respect the decisions, the body, the health and the emotional processes of women. However, regional laws do not regulate criminal procedures.

Policies

In Belgium, the Wallonia-Brussels Federation adopted an [Action Plan](#) to combat Violence Against Women (2022-2024), which pinpoints the prevention of gynaecological and obstetric violence as one of its objectives. Measures include awareness-raising campaigns to inform the public, the provision of information to future mothers on their rights and existing mechanisms in case of need, and trainings of healthcare professionals to sensitize them to Gynaecological and Obstetrical violence, and to improve the management of abortion²².

Research and Monitoring

- **Studies commissioned and funded by governments:** In [France](#), the High Council on Gender Equality (2018) [report](#) on sexism in gynaecology and obstetrics includes 26 recommendations focused on 3 areas: admission of the facts, proposal on how to prevent them through the training of health professionals, and setting up procedures to report and punish any illegal practices. In [Belgium](#), the Citizen Platform for a Respected Birth, with the support of the Wallonia-Brussels Federation, undertook a study with seven recommendations including greater transparency of data and information for patients, establishing a national observatory to tackle gynaecological and obstetric violence, and improved training for healthcare professionals.
- **Observatories:** These have been set up in EU Member States: France, [Italy](#), [Spain](#), and soon in Belgium; following the example of Latin American countries: [Venezuela](#), [Argentina](#), Brazil, [Chile](#), Colombia, Uruguay, Costa Rica, Puerto Rico.

Policy Recommendations

While the studies referred to in this paper do not claim to give an exhaustive picture of gynaecological and obstetric violence in Europe, they nevertheless give a hint of how widespread it is. If we have evidence that the phenomenon of gynaecological and obstetric violence is so prevalent in Europe, why are we failing to act upon it? We call on the EU and its Member States to:

→ Put in place criminal laws

on gynaecological and obstetric violence, that recognise it as a form of institutional gender-based violence and a human rights violation, and prohibit it. At the European level, this could be done, for instance, through the proposed EU Directive on Violence Against Women and Domestic Violence.

→ Adopt policies and protocols

to prevent and address gynaecological and obstetric violence, to fully respect women's choices when accessing gynaecological and obstetric healthcare, including abortion care. These should ensure that 1) transparent, comprehensive, and understandable information is provided to women and people who can get pregnant, 2) patients are always asked their consent for any act carried out on them, and 3) they can file complaints for any violence suffered through independent reporting mechanisms. At the European level, recommendations could be made to Member States through the upcoming EU Recommendation on Harmful Practices.

→ Collect more data on the phenomenon,

at national and EU level, to inform policy decisions, including by carrying out an EU-wide survey through the European Institute for Gender Equality (EIGE), and putting in place national observatories on gynaecological and obstetric violence²³ to monitor the situation. Data collected should encompass all kinds of gynaecological and obstetric violence, including mistreatments during abortion care.

→ Train healthcare professionals

on ensuring a holistic, gender-sensitive, non-discriminatory, and patient-centred approach (including around the right to be informed and consent to any act), and the full application of all relevant WHO guidelines. Healthcare professionals should be trained on both the right medical and behavioural skills, to respect women's right to decision-making over their own bodies, including concerning abortion care.

→ Tackle sexism, misogyny, and harmful stereotypes

about women's decision-making competencies among healthcare professionals. Member States have an obligation to confront the root causes of structural inequality and shift the overrepresentation of men in the field of gynaecology and obstetrics. States must equally address racism and the discrimination experienced by minority groups like women with disabilities and Roma women. This places an enhancing role in the violence women experience.

→ Improve poor working conditions

of health professionals by ensuring health systems have sufficient resources to provide quality maternal health services²⁴.

→ Raise awareness

on the issue of gynaecological and obstetric violence among the general population, and in particular, inform women and all people who can get pregnant of their rights and how to exercise them.

→ Establish constructive cooperation

between medical institutions and healthcare professionals with civil society organisations dealing with SRHR and human rights institutions.

NOTES

1. Art. 15(13), 2007.
2. Art. 6(e), 2009.
3. Many states within Mexico and Brazil, as well as Chile and Bolivia, have a law explicitly condemning and criminalising gynaecological and obstetric violence.
4. The Council of Europe Commissioner has also condemned abusive and coercive practices in maternal healthcare.
5. At the sub-national level, Catalonia defined obstetric violence in its law on violence against women in 2020, which is not a criminal legislation.
6. For the purpose of this paper, we use the term 'women' to designate all people who need gynaecological and obstetric care, while acknowledging that not all of them might self-identify as women.
7. Harmful practices are defined in the Joint general recommendation/general comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the Rights of the Child on harmful practices Section 5.15, p6, as practices which deny the dignity or integrity of the individual, constitute discrimination against women or children, result in harmful consequences (physical, psychological, social, economic...), are kept in place by gender norms, and imposed by family, community, or society at large.
8. As specified by the UN Special Rapporteur on Violence against Women, paragraph III.B.9. More precisely, gynaecological violence can happen at any stage of life, while obstetric violence happens specifically during pregnancy, during and after childbirth.
9. Outside of Europe, incarcerated women are "physically restrained during labour with bed restraints and mouth gags.", a practice condemned by the UN Committee Against Torture and the WHO.
10. Intersex children may still be subjected to medically unnecessary, non-consensual and harmful 'sex-normalising' surgery, a practice condemned by the 2021 EU Strategy on the Rights of the Child. <https://oieurope.org/new-eu-strategy-of-the-rights-of-the-child-affirms-rights-of-intersex-children/>
11. UN Special Rapporteur on Violence against Women, paragraph III.D.49.
12. WHO defines quality of care as care that is: effective, efficient, timely, accessible, acceptable/patient centered, integrated, equitable and safe.
13. In Europe, these include campaigns in: Italy; (#bastatacere: le madri hanno voce); Croatia (#PrekinimoSutnju); France (#PayeTonUtérus); the Netherlands (#Genoeggezwegen); Hungary (#Másállapot); and Finland (the Roses revolution and #Minä Myös Synnyttäjänä). It confirmed that many women had been unaware of being violated, fearful of speaking out due to stigma, or silenced and dismissed.
14. A factor that aggravates the violence suffered by women is the presence and/or active participation of multiple people to such non-consensual internal examinations, for instance by medical students or trainees, often using the lived experiences of women to practice their future profession without informing them or asking for their consent.
15. Paragraph 44, "The denial of safe abortions and subjecting women and girls to humiliating and judgmental attitudes in such contexts of extreme vulnerability and where timely health care is essential amount to torture or illtreatment".
16. The UN Human Rights Committee recognised in *Mellet v. Ireland* that gender stereotypes require that "women should continue their pregnancies regardless of the circumstances, their needs and wishes, because their primary role is to be mothers and caregivers.
17. Women seeking abortion care also face harassment, intimidation and violence perpetrated by anti-choice activists, as recently denounced by the Parliamentary Assembly of the Council of Europe.
18. P. and S. v. Poland – 57375/08, Judgment 30.10.2012 [Section IV] <https://hudoc.echr.coe.int/fre#%7B%22itemid%22:%5B%22002-7226%22%7D>. 'P' was taken to a Catholic priest who tried to convince her to carry the pregnancy to term. Her mother was coerced into signing a consent form warning that the abortion could lead to her daughter's death. They were eventually taken to a police station, where they were questioned for several hours. On the same day, they placed 'P' in a juvenile shelter.
19. The Committee on the Elimination of Discrimination against Women (CEDAW) stated in its General Recommendation no 35 that "[...] forced pregnancy, criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment."
20. In addition, some EU Member States have adopted laws to prohibit obstruction of abortion care, including harassment in front of healthcare facilities providing abortion care (for instance in France, and in Spain recently).
21. The future national legislation on abortion intends to include it as well.
22. This includes learning about techniques on abortion, the importance of dignified practice and non-judgmental communication towards patients, as well as work placements Family Planning Centres.
23. Such as those already present in Italy, Spain and France (and soon in Belgium), inspired by the many pre-existing in Latin America (Venezuela, Argentina, Brazil, Chile, Colombia, Uruguay, Costa Rica, Puerto Rico).
24. Although the onus still lies on healthcare professionals to provide a positive birth experience, adequate staffing and funding are essential to help reduce incidences of violence.



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