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Obstetrical and gynaecological violence

Report¹

Committee on Equality and Non-Discrimination

Rapporteur: Ms Maryvonne BLONDIN, France, Socialists, Democrats and Greens Group

Summary

Obstetrical and gynaecological violence is a form of violence that has long been hidden. In the privacy of a medical consultation or childbirth, women are victims of practices that are violent or that can be perceived as such. These include inappropriate or non-consensual acts, such as episiotomies, or painful interventions without anaesthetic. Sexist behaviour has also been reported.

In recent years, thousands of women worldwide have spoken out, on social networks and in the media, against sexist acts and violence experienced during gynaecological consultations or while giving birth. This violence reflects a patriarchal culture that is still dominant in society, including in the medical field.

Necessary preventive measures should be taken for the human rights and dignity of all to be upheld and human dignity respected, including in the health care context. The adoption of legislation on the informed consent of patients, when not yet the case, awareness-raising campaigns, setting up reporting and complaint mechanisms and adequate financial resources for health care facilities can contribute to providing respectful care to all patients.

1. Reference to Committee: [Doc. 14495](#), Ref. 4378 of 27 April 2018.



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A. Draft resolution²

1. The European Union Agency for Fundamental Rights reports that one in three women in Europe is a victim of gender-based violence. This violence is a violation of human rights and a manifestation of gender discrimination and has long-term consequences on the lives of victims. No area is spared by this scourge, which has been recognised as a public issue for which authorities have a clear responsibility following the adoption and entry into force of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (“Istanbul Convention”, CETS No. 210).
2. The Parliamentary Assembly reiterates its unwavering support for the Istanbul Convention, confirmed in [Resolution 2289 \(2019\)](#) “The Istanbul Convention on Violence against Women: achievements and challenges”. It supports the prevention of and fight against all forms of violence against women and emphasises that awareness-raising activities for the general public are essential in order to put an end to such violence.
3. Obstetrical and gynaecological violence is a form of violence that has long been hidden and is still too often ignored. In the privacy of a medical consultation or childbirth, women are victims of practices that are violent or that can be perceived as such. These include inappropriate or non-consensual acts, such as episiotomies and vaginal palpation carried out without consent, fundal pressure or painful interventions without anaesthetic. Sexist behaviour in the course of medical consultations has also been reported.
4. Obstetrical violence is recognised and punished by law in Argentina and Venezuela. Article 39 of the Istanbul Convention specifically condemns forced sterilisation, but the Convention does not generally address obstetrical and gynaecological violence. Back in 2014, the World Health Organisation (WHO) strongly criticised the disrespectful and abusive treatment that women may suffer while giving birth in hospital. In August 2019, Dubravka Šimonović, United Nations Special Rapporteur on violence against women, its causes and consequences, submitted a report on “A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence” to the General Assembly of this organisation.
5. In a few Council of Europe member States, awareness campaigns have been conducted on social networks and numerous testimonies have been collected in recent years. This greater willingness to talk about the problem and the sharing of experiences have enabled women victims of gynaecological and obstetrical violence to realise that these were not isolated cases. This violence reflects a patriarchal culture that is still dominant in society, including in the medical field. The Assembly reaffirms its commitment to promote gender equality in all areas, which will make it possible to prevent and combat all forms of violence against women, including obstetrical and gynaecological violence.
6. The Assembly commends the work and commitment of health care personnel. It acknowledges that their working conditions in health care institutions can be difficult with staff shortages, limited resources and excessive workloads that can have an impact on the way patients and women about to give birth are treated. Nevertheless, it deplores all forms of violence against women, including gynaecological and obstetrical violence, and calls for all necessary preventive measures to be taken and for the human rights of all to be upheld, in particular in the health care context.
7. The prevention and fight against gynaecological and obstetrical violence are not yet considered priorities, but caring and compassionate practices can be promoted in order to ensure humane, respectful and dignified treatment of and support for patients and women about to give birth. The Assembly fully supports the good practices identified by WHO and encourages their dissemination within Council of Europe member States.
8. In the light of these considerations, the Assembly calls on Council of Europe member States to:
 - 8.1. prevent and combat discrimination on whatever grounds in access to health care in general;
 - 8.2. ensure that care is provided in a manner that respects human rights and human dignity, during medical consultations, treatment and childbirth;
 - 8.3. call on the ministries responsible for health and equality to collect data on medical procedures during childbirth and cases of gynaecological and obstetrical violence, to undertake studies on this subject and to make them public;

2. Draft resolution adopted unanimously by the Committee on 12 September 2019.

- 8.4. disseminate the good practices promoted by WHO and ask national medical associations to discuss this issue and make recommendations to prevent gynaecological and obstetrical violence, in particular through a commission to promote a caring approach in gynaecology;
 - 8.5. conduct information and awareness campaigns on patients' rights and on preventing and combating sexism and violence against women, including gynaecological and obstetrical violence;
 - 8.6. enact and implement legislation on the informed consent of patients and their right to information at the various stages of medical procedures, if this has not yet been done;
 - 8.7. ensure appropriate funding for health care facilities so as to ensure decent working conditions for care providers, respectful and caring reception of patients and women in labour and access to pain relief;
 - 8.8. provide specific training for obstetrician gynaecologists and raise awareness of gynaecological and obstetrical violence as part of this training;
 - 8.9. ensure that the training of doctors, midwives and nurses attaches particular importance to the relationship between care providers and patients, the concept of informed consent, equality between women and men, the reception of LGBTI persons, persons with disabilities and vulnerable persons, communication, the prevention of sexism and violence and the promotion of a humane approach to care;
 - 8.10. propose specific and accessible reporting and complaint mechanisms for victims of gynaecological and obstetrical violence, within and outside hospitals, including with ombudspersons;
 - 8.11. provide for a complaint mechanism for gynaecological and obstetrical violence excluding any mediation, and provide for sanctions, if this is not yet the case, against health-care professionals when a complaint for this kind of violence is proven;
 - 8.12. provide assistance to victims of gynaecological and obstetric violence and ensure that care is provided;
 - 8.13. for those States that have not yet done so, sign, ratify and implement the Istanbul Convention;
 - 8.14. implement Recommendation [CM/Rec\(2019\)1](#) of the Committee of Ministers on preventing and combating sexism.
9. The Assembly also calls on national parliaments to discuss the protection of patients' rights in the context of care and gynaecological and obstetrical violence in order to contribute to public debate and the lifting of taboos.
10. The Assembly encourages non-governmental organisations to continue their efforts to raise awareness and inform public opinion in order to prevent and combat all forms of violence against women, including gynaecological and obstetrical violence.

B. Explanatory memorandum by Ms Maryvonne Blondin, rapporteur

1. Introduction

1. In recent years, thousands of women worldwide have spoken out, on social networks and in the media, against sexist acts and violence experienced during gynaecological consultations or while giving birth. Their stories show once again that gender inequality can lead to violence, even in the health care sector. This issue, which has remained taboo for too long, is at long last being discussed but in most countries, it remains a sensitive and difficult topic to address.

2. Gynaecological violence is violence that women may suffer during gynaecological consultations. They find themselves in a relatively vulnerable position and can be the victims of sexism, humiliation and physical violence during examinations.

3. Obstetrical violence, on the other hand, is violence that women may suffer during childbirth. They may sometimes be treated like children, forced to give birth in a certain position, given excessive medication or made to feel guilty for not wanting to give birth in a standardised way. They may be submitted to certain medical procedures such as induced labour, fundal pressure,³ caesarean sections or episiotomies,⁴ sometimes without their consent or without having been given information on the long-term risks and consequences. Obstetrical violence is punishable by law in Argentina and Venezuela but is still not widely recognised outside South America.

4. In France in recent years there has been a greater willingness to talk about this subject via Twitter and using the #PayeTonUtérus and #balancetongyneco hashtags. The media have picked up on this very intimate subject⁵ and there has been a call for the authorities to take appropriate action. In response to these accounts, Marlène Schiappa, State Secretary for Gender Equality and Combating Discrimination asked the High Council for Gender Equality to carry out a study on this issue. The results of the study, which was published on 29 June 2018,⁶ confirmed what had been stated in the accounts and call for official recognition of the problem, and for preventive measures and penalties. The subject is now being talked openly about in Croatia, where the campaign #prekinimošutnju (“#BreakTheSilence”), launched by the NGO Roda, has encouraged many women to share their experiences.⁷

5. Any form of violence against women is a human rights violation. There are many international instruments to combat violence against women. Few of them specifically mention obstetrical or gynaecological violence. The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (“Istanbul Convention”, CETS No. 210), which is the most comprehensive legal instrument to date in this area, deals specifically with forced abortion and forced sterilisation in Article 39.⁸

6. Back in 2014, the World Health Organisation (WHO)⁹ denounced the disrespectful and abusive treatment that women may suffer while giving birth in hospital in a statement endorsed by 90 organisations. This abusive treatment is a threat to their bodily integrity.

7. Gynaecological and obstetrical violence is not new. It is the result of the continued existence of a patriarchal culture within the medical sector, particularly in the training given to health care staff, and of persistent gender stereotypes in society. In addition, the budgetary restrictions of health facilities, which have become a management objective, hinder the practice of care respectful of the physiology of delivery. Finally, a

3. Manual pressure on the uterus in order to try to accelerate labour.

4. A surgical cut of the perineal area to facilitate the passage of the baby’s head during childbirth. This incision is supposed to prevent more serious tears.

5. “Quand l’accouchement se vit dans la violence, Enquête et témoignages”, Le Figaro; [Quand l’accouchement vire aux violences obstétricales](#), RTBF, 14 January 2018.

6. [Les actes sexistes durant le suivi gynécologique et obstétrical: reconnaître et mettre fin à des violences longtemps ignorées](#), 29 June 2018.

7. “Violences gynécologiques et obstétricales en Croatie: les femmes brisent le silence” [Obstetric and gynaecological violence in Croatia: women break the silence], Le Courrier des Balkans, 25 November 2018; [“Croatian women challenge brutal pregnancy ‘care’”](#), BBC News, Zagreb, 11 January 2019.

8. “Article 39 – Forced abortion and forced sterilisation

Parties shall take the necessary legislative or other measures to ensure that the following intentional conducts are criminalised:

a. performing an abortion on a woman without her prior and informed consent;

b. performing surgery which has the purpose or effect of terminating a woman’s capacity to naturally reproduce without her prior and informed consent or understanding of the procedure.”

9. [Prevention and elimination of disrespect and abuse during childbirth](#), WHO Statement, 2014.

number of professionals do not comply with the recommended good practices (long-banned fundal pressure or episiotomies) and as such, cause violence in care. This issue of non-compliance with the physiology of delivery and good practices is not on the agenda of any institution: colleges, vocational colleges, institutions. We must address this issue at European level and call for women to be treated with respect throughout their lives by everybody, and in particular by health care staff and non-medical staff in charge of their care.

2. Scope of the report

8. The motion for a resolution on which this report is based states that the Assembly should take stock of the situation and make recommendations to member States on the measures which are necessary to change practices and ensure medical care for women, while respecting their rights, their bodies and their health.

9. I do not wish to point the finger at an entire profession, as that would be unwarranted and disproportionate, but rather I would like to help lift the taboos concerning the way women are taken care of and the support they receive in terms of reproductive and sexual health care. Practices which can be perceived as humiliating are still taught and medical staff can, unintentionally, be abusive. The training received by health care staff can be a key factor in preventing obstetrical and gynaecological violence. Without specific training, the way the medical profession thinks and therefore acts will remain unchanged.

10. I have tried to address the structural problems which may lead to the ill-treatment of patients, in particular staff shortages resulting in longer working hours and the need to attend to several patients at the same time during childbirth. This report does not deal with access to contraception which will be the subject of a future report by Ms Petra Bayr (Austria, SOC). Nor does it specifically address access to abortion. I will also not be looking at the question of access to care for women with disabilities, the particular difficulties they may face when giving birth and the discrimination they suffer.

3. Working methods

11. I began my work by researching the available literature, and I wanted to do this in co-operation with health care professionals, patients and victim support organisations. On 10 October 2018, I met Ms Marie-Amélie Schmelck, a midwife in Strasbourg. She spoke to me about midwives' working conditions and about an environment that has become less patient-friendly in recent years. She told me that medical staff were taught the "mechanics" but not "empathy" and she feels that "violence towards patients is a daily occurrence in many maternity wards for structural, cultural and sociological reasons".

12. The committee held a hearing on 3 December 2018 with Dr Amina Yamgnane, Obstetrician-Gynaecologist and Head of the Maternity Department at the American Hospital in Paris, and Ms Anne-Mette Schroll, consultant, midwife, representing the Danish Association of Midwives.

13. The committee held another hearing on 24 January 2019 with Dr Özge Tunçalp from the World Health Organisation. I was also able to talk about the issue with Ms Liliane Maury Pasquier, the President of our Assembly and a midwife by profession.

14. On 9 April 2019, the committee held a joint hearing with the Parliamentary Network Women Free from Violence on the specific issue of forced sterilisation of Roma women, with Ms Elena Gorolová, spokesperson for the Group of Women Harmed by Forced Sterilisation (Czech Republic), Ms Gwendolyn Albert, a human rights advocate (Czech Republic), Mr Adam Weiss, Director of the European Roma Rights Centre (Budapest), and Mr Stefan Ivanco, programme co-ordinator and researcher, Poradňa, Centre for Civil and Human Rights (Slovak Republic).

15. On 3 and 4 July 2019, I carried out a fact-finding visit to Croatia, during which I met Dr Željko Plazonić, State Secretary at the Ministry of Health, Ms Tena Šimonović, Deputy Ombudsperson, members of parliament and representatives of non-governmental organisations. I had discussions with Ms Ninčević Lesandrić, MP, who had given an account of her own experience before the Croatian Parliament; this launched the *#Breaking the silence* campaign on social networks. I also had the opportunity to visit a large maternity hospital and meet health care staff, gynaecologists and obstetricians, midwives and nurses. I was able to talk to women who had given birth in this maternity hospital.

16. Ms Dubravka Šimonović, UN Special Rapporteur on Violence against Women, its causes and consequences, prepared this summer a report on "A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence". We discussed our recommendations during a meeting at the Croatian Parliament. Her report was submitted to the 74th session of the United Nations General Assembly in August 2019.¹⁰

17. I would like to thank the Croatian Parliament for its support in the preparation and conduct of my fact-finding visit, during which I met a variety of people from different backgrounds to discuss this issue, and the medical staff for their availability. I chose to make a fact-finding visit to Croatia because of the testimony given by a member of parliament and the impact this had had on social networks. Gynaecological and obstetrical violence is a widespread phenomenon and women are victims in many countries. I am not able to assess the extent of this violence throughout Europe, but by cross-checking testimonies and talking to health professionals, I can say that there are practices that can lead to such violence and that the lack of resources allocated to health care facilities has an impact on patient care and can also lead to so-called institutional violence as a result of insufficient time, equipment or staff.

4. Forms of gynaecological and obstetrical violence

“Brutal or inexperienced vaginal palpation, episiotomies carried out without consent, fundal pressure, membrane stripping, condescending remarks and refusal to allow women to give birth the way they want to; there are numerous accounts confirming how frequent gynaecological and obstetrical violence is. The term itself has angered specialists who perhaps forget that it is not the practitioner’s deliberate actions or words that justify using such a term, but the feelings and after-effects experienced by those subjected to them.” Camille Froidevaux-Metterie.¹¹¹²

18. First of all, I would like to point out, as did Dr Yamgnane during our hearing, that in France there is a medical risk in 20 to 30% of births. In such cases, it is necessary to use forceps or suction cups, carry out a caesarean section, an examination of the uterine cavity, stop bleeding or have recourse to neonatal resuscitation services. According to her, some professionals do not wish to frighten patients and therefore can choose to understate the potential risks during their pregnancy or childbirth. Sometimes they may also have to take swift decisions, without asking the patient, in an emergency or if the patient’s or baby’s life is at risk. Complications during childbirth are not always predictable, and this can have an impact on the way women in labour are dealt with. Childbirth can be a painful and traumatic experience, far from the perfect delivery that had first been imagined.

19. Gynaecological and obstetrical violence can take many forms and it is difficult to have an overall idea of the number of victims. It is not easy to obtain precise information. Anne-Mette Schroll, a Danish midwife, shared her experience at our hearing and debunked a common misconception about the treatment of women patients in Denmark:

“I was under the impression that Danish women were well treated in our maternity wards. We conducted a survey that showed that 25% of the women interviewed had some experience of violence in our facilities.”

20. According to the French National Academy of Medicine, which published a report entitled “A caring approach in obstetrics. The reality of maternity wards”, “the term ‘obstetric violence’ covers any medical act, posture, or intervention that is inappropriate or to which no consent has been given. It therefore covers not only acts that do not comply with clinical practice guidelines (CPG) but also medically justified acts carried out without prior information and/or without the patient’s consent or with clear brutality. In addition, attitudes, behaviours or comments that fail to respect women’s dignity, modesty and privacy are also included in this term and are related to the failure to take into account the pain experienced during and after childbirth.”¹³ Medical acts and invasive procedures are sometimes performed in the absence of consent during gynaecological examinations.

21. Medical students in several countries have practised vaginal palpation on patients under anaesthesia who are still unconscious.¹⁴ Shocking revelations in the press have shown us that certain practices perceived as part of a curriculum could be considered as invasive practices against patients. During our hearing, Dr

10. The report is available online: reference [A/74/137](#).

11. *Camille Froidevaux-Metterie, Le corps des femmes, la bataille de l’intime*, p. 129, Editeur Philosophie magazine, 2018.

12. In *Le Livre noir de la gynécologie – Maltraitements gynécologiques et obstétricaux: libérer la parole des femmes* (Black book of gynaecology), published in 2017, Mélanie Déchalotte, journalist, presents a variety of testimonies of patients who have been victims of gynaecological and obstetrical violence.

13. This report was published on 18 September 2018, www.academie-medecine.fr/wp-content/uploads/2018/09/18.9.18-Rapport-CREPIN-bientraitance.pdf.

14. *Toucher vaginal sur patientes endormies: des médecins alertent le gouvernement*, Libération, 6 February 2015.

Yamgnane shared her own experience: “In the 1990s, during my medical studies in Brussels, I learned to make vaginal palpations on women under general anaesthesia. It never occurred to me during my studies to question this type of practice.” She told us that she subsequently realised that this practice was unacceptable.

22. It may be necessary, in order to save lives, to perform invasive operations or manipulations without the patient’s consent, for example, when emergency Caesarean sections must be performed where there is a risk to the mother or the child. But in some clinics, the number of Caesarean sections performed is greater than the number medically necessary (between 10 and 15%), which raises the question of whether Caesarean sections are imposed or whether women request them.¹⁵ There are some practitioners who, for personal reasons due to scheduling or other constraints, may impose a delivery date on their patient by promoting the merits of a scheduled Caesarean section delivery, which is less dangerous and traumatic than an emergency Caesarean section. There are also women who wish to deliver by Caesarean section and find practitioners who are willing to schedule Caesarean sections that may not be necessary. The number of Caesarean section deliveries varies greatly from one country to another.

23. Episiotomies are another practice that may be perceived as violence and that warrant analysis. An episiotomy is an incision in the perineum to allow the new-born child to pass through more easily and prevent serious tears. Although it was a relatively common practice for first-time mothers giving birth vaginally in certain health care facilities in France (20% on average, 34.9% among first-time mothers),¹⁶ it is virtually no longer used in some maternity hospitals which dispute its usefulness. With only 1% of episiotomies, the Besançon maternity hospital in France serves as an example and its patients have no more complications than those of other maternity hospitals. This incision is not always necessary and is sometimes made merely to speed up delivery. It can have serious consequences, not only physically but also psychologically. It can be performed without asking or waiting for the patient’s consent, or without informing her of any possible consequences. There is a real lack of communication between practitioners and patients on this subject. The World Health Organisation recommends that the percentage of episiotomies should not exceed 20%. Dr Yamgnane stated that she had never met a patient who had consented to having an episiotomy. Once the mother is in labour, it may be difficult to obtain informed consent.

24. An episiotomy can cause complications for patients who sometimes discover only after the birth that it has been carried out.¹⁷ Healing of stitches can be painful and a woman may have difficulty sitting down due to a poorly performed episiotomy. Stitches may break and abscesses may form. The psychological effects can be even more significant. I believe that an episiotomy performed unnecessarily and without consent is a violation of a woman’s physical integrity.¹⁸ We must ask why this practice is still used in some hospitals when it is not a medical necessity. We can also wonder why some women having given birth seem not to be informed about the fact that an episiotomy has been performed or why some doctors downplay the potential consequences of this practice, making future mothers who do not want one feel guilty. The quality of life of the patient, once out of the delivery room, is not necessarily a priority.¹⁹

25. Denial of access to pain relief or an epidural may also be considered a form of violence. There are some (albeit few and far between) practitioners who believe that patients should give birth in pain. Access to epidurals is not yet widely provided across Europe, nor is it well-regarded.

26. In the documentary “Tu enfanteras dans la douleur”, (*You shall give birth in pain*), broadcasted on the ARTE channel on 16 July 2019, Ovidie, the film director, presents the testimonies of women who have been victims of gynaecological and obstetrical violence. I was particularly moved by the testimony of a woman who said she had been killed from the inside.

27. During my visit to Croatia, I had the opportunity to have a long discussion with Ms Ivana Ninčević Lesandrić, MP, who had shared her experience of curettage without anaesthesia following a miscarriage in a hospital in Split. “This brutality creates physical and psychological trauma and is a form of violence. I was left there with no information, no choice, tied to a bed for curettage without any pain relief. I felt every second of this medical procedure”. She remembers the look on the face of the gynaecologist who performed this procedure. She said nothing, but Ms Ninčević Lesandrić felt that she was sorry for the conditions of the

15. [Les gynécologues mettent en garde contre une “épidémie de césariennes” dans le monde](#), France TV info, 12 October 2018.

16. *Ibid.*

17. If an epidural is used, patients should not be in any pain during an episiotomy.

18. Unnecessary episiotomies for which no consent has been given do not fall within the Istanbul Convention’s definition of female genital mutilation.

19. [Derrière le “point du mari”, le traumatisme de l’épisiotomie](#), (Behind the “husband stitch”, the trauma of episiotomies), *Le Monde*, 18 April 2014.

treatment she was being given. Following her testimony, she was accused of lying about her experience. But she received hundreds of emails from women sharing their experiences and thanking her for speaking out in public. The testimonies of Croatian women on social networks reveal harshness of the medical staff towards them and the utter disregard for pain.

28. The so-called “husband stitch” remains a taboo subject. Some doctors add a few extra stitches when they sew up the perineum after an episiotomy or tear.²⁰ These additional stitches are believed to increase the pleasure of the husband or partner during sexual intercourse. This is said to restore a vagina typical of a young girl, which supposedly is more appealing to men. However, the “husband stitch” can make sexual intercourse very painful for women, although this does not seem to be a major concern of those who perpetuate this practice.

29. Fundal pressure is another widely criticised practice. There are no quantitative data on its application. It can be a difficult experience since women are no longer in control of their childbirth. This practice has been prohibited in France since 2007. It may be difficult for a woman who gives birth, exhausted by hours of labour, to object to a practice that the obstetrician/gynaecologist considers necessary in order to speed up delivery. The woman is in a vulnerable position and caregivers have a degree of authority over their patients who defer to their judgment and recommendations.

30. Labour may be induced if the pregnancy goes beyond term or if there is a risk to the unborn child or mother. It can be very painful for the patient, triggering and accelerating contractions faster than what would happen naturally. Induction may not work or else entail extremely lengthy and particularly painful labour, as every patient reacts differently. Artificial hormones are also frequently used to speed up labour. Oxytocin perfusions may be given without the patients’ consent. The objective is not systematically to prevent certain risks in the event of delayed delivery, but also to reduce the duration of labour and to free up labour and maternity wards so that new patients can be admitted, for the sake of cost-effectiveness. These practices can be regarded as forms of violence if they are used by professionals for reasons other than the health of women and the unborn child. According to the French National Academy of Medicine, “the very frequent failure to provide information on the reasons, the expected benefit, the procedure, the duration and the risk that these forms of induction may not work, has given rise to widespread dissatisfaction”.²¹

31. During our hearing, Dr Özge Tunçalp stated that abuse during childbirth may take a variety of forms, such as physical assault, sexual abuse, insults, prejudice and discrimination, poor relationships between women and care providers (no informed consent, no pain relief) and failure to meet professional standards of care. She further stressed that not suffering abuse did not necessarily mean being treated with respect. As a parliamentarian, I believe that we should work tirelessly to promote respectful and non-discriminatory attitudes towards women in general, including in health care systems.

32. Obstetrical and gynaecological violence can have serious consequences for patients’ short-term and long-term health, which can have repercussions for their babies. These consequences are still underestimated. Post-partum depression and post-traumatic stress syndrome may be linked to obstetrical or gynaecological violence,²² and lead to a deterioration of mother-child relationship in the months following birth.

33. In addition, obstetrical and gynaecological violence affects patients’ confidence in the medical profession and may make patients reluctant to attend consultations. This can have serious repercussions for their reproductive health.

34. Gynaecological and obstetrical violence is traumatic for both emotional and sexual life years after the incident. In her book “Le livre noir de la gynécologie”, Mélanie Déchalotte says that many women use the term rape when talking about gynaecological violence. The use of instruments such as a speculum or scissors, and instances of fingering without consent, can be considered a violent intrusion in a person’s body.

20. Ibid.

21. “De la bientraitance en obstétrique. La réalité du fonctionnement des maternités” (A caring approach in obstetrics. The reality of maternity wards), Académie nationale de médecine, 18 September 2018.

22. [The association between disrespect and abuse of women during childbirth and postpartum depression: Findings from the 2015 Pelotas birth cohort study.](#)

5. Unequal relationships between the medical profession and women patients

“About 20 years ago, I walked into the room where I performed terminations of pregnancies, closed the door and lay on the examination table, with my legs in the stirrups. It changed the way I see and exercise. I’ve done it regularly, over the years...”, Martin Winckler, doctor.²³

35. This report prompts us to reflect on the unequal relationships between the medical profession and women patients. A relationship of superiority, built on a perceived superiority of one gender over another or of the profession of doctor in relation to patients, can lead to treatment that is felt to be degrading or clearly violent. The opposite is also possible, with patients who can be aggressive towards medical staff or question their actions.

36. I was shocked to learn that at the Congress of Gynaecologists/Obstetricians, which took place in Strasbourg on 7 December 2018, a slide was projected comparing women to mares: “Women are like mares, those with large hips are not the most pleasant to ride, but they are the ones who give birth the most easily”.²⁴ Some women feel that it is the professionals who “deliver” the baby and they are thought not to be capable of taking a full part in the delivery. When women are not treated as children, they are dehumanised. With this report, I wish to promote better treatment and more egalitarian relations between the medical profession and women patients. We also find a determination to control delivery: the position, the place and the follow-up. Birth plans are still too often ignored and patients’ views disregarded.

37. The taboo around women’s bodies is an opportunity for domination. Patients will not dare to confront a doctor because they are embarrassed to talk about intimate matters. They will also not complain if there is violence, which can have devastating consequences. Nor will they necessarily object to practices they consider to be humiliating or invasive, not wishing to go against the health care staff.

38. Deciding not to have children may be a choice and is described by some as emancipation.²⁵ Nevertheless, young women who have not had children face many difficulties, or even refusals, if they wish to be sterilised. Doctors send them to psychologists and tell them that they may subsequently regret this choice. Sterilisation is rarely practised in Europe, whereas it is common in North America and India, for example. The decision not to have children is not considered final and for many women is met with platitudes such as maternal instinct, the biological clock or the desire for a child at a later stage. Women having made this choice are misunderstood and stigmatised in our societies. Despite years of progress in the gender equality field, women, whatever positions they hold, continue to be regarded in terms of their potential future role as mothers. It seems that the medical establishment, like society in general, finds it hard to accept that a woman may choose to live her life without children, whatever the reason.

39. In the same vein, women are urged to have children once they have turned thirty; they are told not to wait too long, and pregnancies of women who are 35 or over are known in some medical circles as “geriatric pregnancies” or potentially high-risk. Women are judged, criticised and expected to conform throughout their sexual lives. No heed is paid to what they actually want.

40. Gynaecological consultations and childbirth are intimate moments in the life of women, during which they are particularly vulnerable. At our meeting in the Croatian Parliament, a male doctor and member of parliament said that he too felt particularly vulnerable and a victim of violence during medical examinations while he was being treated.

5.1. Discrimination against lesbian women

41. Medical examinations can be carried out roughly by some practitioners. In testimonies posted on social networks, many women have reported comments made by gynaecologists, criticising their lifestyle, sexual orientation or appearance. Lesbian women may be stigmatised by some doctors or even humiliated during consultations, which may lead them to stop having regular medical check-ups.

42. According to the European Union lesbian, gay, bisexual and transgender survey conducted by the European Union Agency for Fundamental Rights (FRA)²⁶ one in ten of the respondents who had accessed health care services in the year preceding the survey reported that they had felt personally discriminated

23. Twitter account of Martin Winckler @MartinWinckler, 26 May 2019.

24. This quotation came from the book *Le Seigneur de Châlus* by Yves Aubard (2012), a historical novel set in the Middle Ages between 967 and 969.

25. *Camille Froidevaux-Metterie, Le corps des femmes, la bataille de l’intime*, op.cit.

26. [EU LGBT survey: European Union lesbian, gay, bisexual and transgender survey - Main results](#).

against by health care personnel. LGBTI people encounter two main obstacles to medical care: access and the attitude of health care professionals towards LGBTI people. It would seem, for example, that lesbians are not routinely offered cervical cancer screening, being considered a low-risk group.

43. When LGBTI people use a health service, the care providers often presume heterosexuality and may use inappropriate language, thereby contributing to the invisibility and exclusion of lesbians and bisexuals. As some surveys have shown,²⁷ denial of care based on discrimination is ill-treatment and encourages patients to relinquish their right to care. The case of gynaecological care for lesbians is very telling: the rate of sexually transmitted infections is higher for this population group than for heterosexual women since the former have stopped going for gynaecological examinations following denial of care.²⁸ In France, some 12% of women who have sex with women have contracted an STI in recent years,²⁹ as against 3% for heterosexual women.³⁰ Gynaecological health care ought to be an ideal opportunity for prevention and screening. Yet lesbians are often denied such care or given poor advice.

44. I will not give details on the situation of intersex people in this report but invite you to consult the report by Mr Piet De Bruyn, former member of the Assembly, on the situation of intersex people in Europe and the discrimination to which they are subjected.³¹

5.2. Forced sterilisation

45. Forced sterilisation is one of the most serious forms of violence, as it takes away a woman's ability to decide whether or not she wishes to have a child. It is never needed in order to save lives: there are other, non-irreversible, methods of contraception that can be offered to a woman for whom a pregnancy would constitute a serious health risk.

46. The Istanbul Convention calls on States Parties to criminalise forced sterilisation. GREVIO's first evaluation reports show that these States Parties take different approaches to forced sterilisation. Some States, such as Monaco and Albania, have not criminalised this practice. GREVIO is encouraging the Albanian authorities to introduce the offence of forced sterilisation into criminal law and has found shortcomings in this field.

47. However, GREVIO notes that forced sterilisation has been criminalised by the majority of States covered by evaluation reports. This is the case for Turkey, which has made forced sterilisation a criminal offence under Article 101 of the Turkish Criminal Code. In Denmark, forced sterilisation is a criminal offence. GREVIO calls on the Danish authorities to widen the provision of telephone counselling currently available to include forced sterilisation. In their report submitted to GREVIO,³² the Austrian authorities stated that Austrian law makes forced sterilisation a criminal offence, regarding it as "bodily harm", and making it punishable by a sentence of one to 15 years.

48. GREVIO's report on Portugal indicates that Article 144 of the Criminal Code covers forced sterilisation and makes it a criminal offence. It encourages Portugal to go further and address, through research, all forms of violence against women, such as forced sterilisation. Montenegro amended its Criminal Code in 2017 to include criminalisation of forced sterilisation. However, GREVIO expresses regret that there are no prevention and protection measures to accompany these legislative changes. Generally speaking, GREVIO welcomes States' legislation criminalising all forms of violence against women, but encourages States to go further by, for example, improving prevention and care for the victims.

49. In its [Resolution 1945 \(2013\)](#) "Putting an end to coerced sterilisations and castrations", the Assembly called on member States to "revise their laws and policies as necessary to ensure that no one can be coerced into sterilisation or castration in any way for any reason" and "ensure that adequate redress is available to

27. "VIH, Hépatites, la face cachée des discriminations", 2016 Aids report. "Résoudre les refus de soins", annual report on enforcement of health system users' rights, adopted in the plenary session of the French National Health Conference on 10 June 2010.

28. Clotilde Genon, Cécile Chartrain and Coraline Delebarre, "[Pour une promotion de la santé lesbienne: état des lieux des recherches, enjeux et propositions](#)" ("Promoting lesbian health: state of the art, issues and recommendations"), Genre, sexualité & société, 2009.

29. CNCDDH, Agir contre les maltraitances dans le système de santé une nécessité pour respecter les droits fondamentaux, 22 May 2018, p. 28.

30. Cécilia Giles, "Le suivi gynécologique des femmes ayant des rapports sexuels avec des femmes. Déterminants, enjeux, perspectives", Gynécologie et obstétrique, 2018. dumas-01925322.

31. [Resolution 2191 \(2017\)](#) "Promoting the human rights of and eliminating discrimination against intersex people" and [Doc. 14404](#).

32. State report: [GREVIO/Inf\(2016\)2](#).

victims of recent (and future) coerced sterilisation or castration, including the protection and rehabilitation of victims, the prosecution of offenders and financial compensation which is proportionate to the seriousness of the human rights violation suffered". I applaud Ms Maury Pasquier's report on this very difficult subject. She presents a detailed study of the situation of not only Roma women, but also transgender people, persons with disabilities and "the marginalised, stigmatised, or those considered unable to cope", who have been victims of forced sterilisation or castration.

50. This report gives me the opportunity to make the point that Roma women may also find themselves in a particularly vulnerable situation, whether during routine gynaecological examinations or when they give birth. They may experience poor care, poor treatment, be stigmatised, humiliated or moved to a separate section of the maternity ward. Roma women have sometimes been the target of deliberate obstetrical violence, such as forced sterilisation.

51. Elena Gorolová, spokesperson for the Group of Women Harmed by Forced Sterilisation in the Czech Republic, recounted her personal experience to the committee during a hearing held in April 2019. She was forcibly sterilised in 1990, immediately after having given birth to her second child by caesarean section. She had no opportunity to give free and informed consent, being simply asked, during her confinement, to sign a paper without anyone explaining what it was actually about. She felt devastated upon learning that she could not have any more children. She has been campaigning for years in the Czech Republic to obtain compensation for the injury caused but has been heavily criticised for what she is doing, as much by her community as by the authorities.

52. According to Adam Weiss, Director of the European Roma Rights Centre, forced sterilisation is intersectional discrimination and has been practised in a number of Council of Europe member States. For instance, the United Nations Human Rights Committee has asked the Slovakian Government to establish an independent body to investigate the full extent of forced sterilisation.³³

5.3. Denouncing sexism in the medical field

53. We may also ask ourselves why women's health and the female body are still perceived as taboo. Women's bodies belong to them, the issue of gynaecological and obstetrical violence raises questions about our progress in terms of gender equality and equality in general. The words of the women who testified about the gynaecological and obstetrical violence they have experienced have been attacked and downplayed by some doctors.³⁴ It is important to remind that, in countries where it exists, the Patient Charter stipulates that the informing patients of medical procedures is mandatory as well as respect for their privacy.

54. Martin Winckler, doctor and writer, says that health professionals are incapable of self-questioning: "The problem of gynaecologists is their paternalism, this way they have of thinking they know everything. In addition, they think they are morally superior, even more so with women because of the prevailing sexism. They need to review their thinking."³⁵ I do not wish to generalise. We should be reflecting, as Dr Yamgnane pointed out at our hearing, on how to "do what we do better, and not stigmatise".

55. The sexism of some doctors may entail a disregard for pain. Many endometriosis sufferers have taken years to identify their condition because their pain has been systematically downplayed by their gynaecologists. Women may also sense an indifference to pain during routine examinations or when an IUD is inserted.³⁶

56. In Finland, a "Me too during childbirth" information campaign («Minä myös synnuttäjänä») was initiated by midwives, doulas and women who have given birth to promote the right to respect during childbirth and the right to information. "We demand that the right to self-determination laid down in Finnish law and international human rights agreements be upheld in full within Finnish maternity care and hospitals. We seek a cultural shift towards consent being taken as the basic principle of maternity care. The birthing mother must be assisted and cared for in the way required by the law: in full cooperation with her." This campaign underlines the need to acknowledge that obstetrical violence is a reality in Finland as in other parts of the world. This collective states that "Birth is a part of a woman's sexuality, and the experience and consequences of obstetric violence are much the same as other sexual violence. Because of this, obstetric violence must be considered as a form

33. Human Rights Committee, Concluding observations on the fourth report of Slovakia, adopted on 31 October 2016.

34. [\(Don't\) pay your gynaecologist – Documentary](#) – Nina Faure (2018).

35. "Contre les violences gynécologiques, la lutte prend corps", Catherine Mallaval and Anaïs Moran, *Libération*, 15 August 2017.

36. [Violences gynécologiques: rencontre avec Martin Winckler](#), *Antigone XXI*, 4 December 2018.

of sexual violence. The difference to other sexual violence is that in maternity care the professional's power is institutional and medical. The perpetrator may also defend their actions by claiming that they were in the mother's or baby's best interest."³⁷

57. In Croatia, inspections have been carried out in hospitals following #breakthesilence but the results have not yet been made public. As in other countries, hospitals are under-resourced and understaffed. There is reported to be a lack of analgesics and anaesthetics in some hospitals. Many health professionals have gone abroad to work. Victims have spoken of the difficulty of reporting gynaecological or obstetrical violence in hospitals. A female doctor told me that she could not agree to the use of the term violence, because it would imply that a health professional was trying deliberately to inflict pain on patients. It is important to note differences in facilities between large cities and more rural areas, including islands, where health care establishments may be less well equipped or very remote.

58. There has been a fall in the number of episiotomies in Croatia (13,934 in 2012 and 9,035 in 2018). In 2018, 67.5% of vaginal deliveries were without an episiotomy. During the visit to the maternity ward of Petrova Hospital in Zagreb, I was told that all patients are informed of all medical procedures during a consultation or delivery. A team of gynaecologists, surgeons, urologists and anaesthetists is addressing the issue of endometriosis treatment (ranging from medication to surgical interventions). Gynaecologists are required to renew their licence every six years in Croatia, which gives them the opportunity to update their skills. The doctors I met told me of their commitment to providing human-oriented care and their desire that all deliveries and other procedures should go smoothly. I also met women who seemed very satisfied with how their childbirth had gone. Every birth, every pregnancy, every patient is unique.

59. In Italy, the #bastatacere (Enough silence) twitter movement has collected a large number of testimonies. A study referred to in the documentary "You shall give birth in pain", claims that 21% of Italian mothers have already suffered obstetrical violence and that 64% of episiotomies were carried out without consent.

6. Institutional or structural violence

60. So-called institutional or structural violence results from the way services are organised, lack of time and of staff and the need for cost-effectiveness. The time required to ensure that patients are cared for in the best possible way is not the same as the time it takes to comply with economic requirements. Similarly, professionals no longer have time to discuss any traumatic experiences they have had in the delivery room and be given the necessary follow-up. Health professionals often work in difficult conditions, and many hospitals are understaffed, which affects patient care. Young mothers are frequently encouraged to return home as soon as possible without being given any support after leaving hospital. Health care professionals stress the importance of having sufficient resources in hospitals.

61. Without wishing to advocate for childbirth at home, in a maternity facility or in a hospital, I maintain that a caring reception and follow-up for patients and compassionate support during pregnancy and childbirth and the postnatal period are essential. In birthing centres, the organisation provides for one midwife per patient, while in hospitals, a midwife may be in charge of three to five women at the same time. This disparity of means raises questions. More effort needs to be focused on preparation for childbirth, which should be an opportunity for sharing information, discussions on violence prevention and preparation for the birth project and its follow-up.

62. Failure to take into account the past experience of the patient, who may have been the victim of other forms of violence, can make her relive this experience and cause her pain. Lack of time and the requirements of efficiency and cost-effectiveness mean that physicians spend less time with patients, and therefore do not ask questions about their past experiences, and this can lead to complications and a re-experiencing of trauma. In a society where time spent with women who are about to give birth is limited, it may be difficult to provide the compassionate care that is so important.³⁸ Here too, early antenatal examination is a tool to discuss vulnerabilities and agree with the team on an individualised care path.

37. [Minä myös synnuttäjänä; Report on the Mistreatment and violence against women during reproductive health care and childbirth in Finland – A response to the call for submissions by the OHCHR-UN.](#)

38. ["Violences obstétricales: et si la solution, c'était de prendre le temps?" \(Obstetrical violence: what if time was the key?\), RTBF, 9 February 2019.](#)

7. Good practices and recommendations

63. The key issues in the report are gender equality and respect between medical staff and patients. I believe that obstetrical and gynaecological violence and abuse can be prevented. It generally reflects a certain mindset and a contempt towards women. It testifies to a desire for domination and perpetuates a patriarchal culture that we should be seeking to end. Promoting gender equality in every field will help combat all forms of violence against women, including obstetrical and gynaecological violence.

64. This subject is regarded as taboo by some people and as something that should remain in the private sphere, like other forms of violence against women. Obstetrical and gynaecological violence affects women when they are particularly vulnerable: before, during and after childbirth, during a visit to the doctor, or even when put to sleep by an anaesthetic. This violence is pernicious and can be invisible. It is often internalised by the women who suffer it, who are told that it is one of the hazards of childbirth and are required to accept the pain and stop complaining. Yet obstetrical and gynaecological violence is not inevitable. We must endeavour to break the taboo and call for patients to be treated with respect, including in emergencies.

65. To have a clearer idea of the extent of this violence, it is important to undertake data collection by calling on member States to collect data on consultations, childbirth and acts of gynaecological and obstetrical violence from hospitals, health care professionals (doctors, midwives, nurses) and patients. Analyses of these data will have to be carried out in order to identify priority areas for action and urgent problems that need to be addressed.

66. Putting patients at the heart of health care systems again ought to be a priority. This means allocating adequate funding to health care facilities so that they are properly responsive to patients, their backgrounds and their needs. The entire health care system must put in place the conditions needed for respectful care and ensure that sufficient funding is given to health facilities for patients to be treated with dignity and respect.

67. My wish is obviously not to attack the profession but rather to direct attention to force of habit in medical practice. Health care staff training ought to include, if it does not already, specific courses on the doctor/patient relationship, the notion of consent, gender equality, care for LGBTI people and vulnerable persons and prevention of sexism and violence.

68. In 2018, WHO published recommendations on intrapartum care for a positive childbirth experience³⁹ according to which an intervention should not be undertaken in the absence of a clear medical indication. Routine or liberal use of episiotomy is not recommended for women undergoing vaginal birth. Fundal pressure to facilitate childbirth during labour is not recommended either. WHO makes clear that all women are entitled to a positive experience of childbirth and, in particular, respect and dignity, support from a companion of their choice, effective communication by maternity staff, pain relief strategies, mobility in labour and birth position of choice.

69. Certain clinical protocols may be perceived or experienced as violent. Strict, unbending compliance with them may mean that doctors use practices that can be perceived as rough. A decision to perform an emergency caesarean may be taken very swiftly in order to save life, but the operation may be upsetting to the patient. Keeping patients informed whenever possible, explaining the protocols and taking a compassionate approach to care could lead to a change in practice.

70. Legal provisions penalising obstetrical and gynaecological violence are not yet widespread. We should therefore be pressing for the drawing up of such provisions. Medical associations should introduce penalty systems for doctors who fail to behave respectfully towards their patients. Similarly, sexist remarks and attitudes among caregivers should be clearly prohibited and punished, as they should in all professions.

71. Simplified mechanisms for filing complaints within and outside hospitals should be accessible and ensure the protection of victims. They may file a complaint for lack of information, lack of consent, and wrongful practice of fundal pressure or episiotomy.

72. Many women who have suffered violence of this sort do not realise it. Information and awareness-raising campaigns ought to be conducted to alert public opinion to these risks and acts and encourage victims of violence to lodge complaints. Continually making it easier to talk about obstetrical and gynaecological violence will help to change practices.

39. World Health Organisation (2018), [WHO recommendations: Intrapartum care for a positive childbirth experience: transforming care of women and babies for improved health and well-being: executive summary](#).

73. Sharing of good practice to combat and prevent obstetrical and gynaecological violence should be encouraged. Access to information should also be provided. Of course, financial resources are necessary to prevent so-called structural violence, but a change in mentality and active promotion of gender equality from an early age, as well as during medical studies, might give people cause to think about medical practice and help change attitudes and prevent violence.

8. Conclusions

74. Gynaecological and obstetrical violence reveals a gender inequality that is deeply rooted in our societies. Women's voices are not heard and are even considered less important. Women are no longer fully involved in their childbirth but, it is claimed, are guided by their emotions, are vulnerable and unable to make rational decisions. These acts of violence show us that gender stereotypes have an impact not only on women's place in society but also on access to care and treatment. Danièle Bousquet, former president of the French Supreme Council for Gender Equality, said that such violence reveals a desire for control over women's bodies. It is time to intensify our efforts to promote gender equality in all areas in order to put an end to such practices.

75. Women victims of gynaecological and obstetrical violence are victims of both patriarchal and institutional domination. However, such violence is not inevitable and can be prevented. Medical practices are perceived by some patients as dehumanising. Compassionate support for patients during consultations and monitoring post-illness and during childbirth should be the norm. I would like to stress that health care workers should not be stigmatised but should be guided, trained and supported in order to ensure that patients and women about to give birth are received and treated with dignity and compassion. The force of habits, technical procedures carried out mechanically, automatic reflexes and a lack of personnel and resources can all have negative consequences for patients.

76. Taking the time to listen to women, respect their choices and provide them with information are essential for preventing gynaecological and obstetrical violence. We must work together to ensure that women can have control over their bodies, be involved in their childbirth and experience true equality, free from violence and stereotypes. This is not a purely technical question but rather a question of respect for human rights, for which a political commitment can make a valuable contribution.