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OBSTETRIC VIOLENCE AND FORCED STERILIZATION: CONCEPTUALIZING GENDER-BASED INSTITUTIONAL VIOLENCE

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The twenty-first century continues to witness gynecological abuse in the form of forced sterilizations of minority women. In many parts of the world, states weaponize family planning programs as a form of reproductive policy against poor women and women of color, treating women's fertility as a drain on the state's resources. The first part of this Article discusses how legal systems around the world do little to provide redress for women who are coerced to undergo certain medical procedures during, before, and after childbirth, and give little consideration to their right to bodily autonomy. The second part of the Article centers on obstetrics to illustrate how women's bodies remain a site of profound gendered power differentiation. In Latin America, the pervasiveness of abusive practices in obstetric and gynecological care fomented a grassroots childbirth rights advocacy movement. One of Latin America's first victories was Argentina's adoption of a legal framework in

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2004, which introduced a human rights-based approach to childbirth.[1] Later, in its 2007 law creating a comprehensive framework to protect the "right of women to a life free of violence," Venezuela included "obstetric violence" in categories of gender-based violence.[2] More recently, the Committee to the U.N. treaty body on the Convention on the Elimination of Discrimination against Women (CEDAW), in its decisions under the Convention's Optional Protocol, has defined obstetric violence in a way that is now firmly embedded in the normative structure of international law.

Although "obstetric violence" seems on its face to be part of the continuum of disrespect and abuse in obstetric and gynecological care, the CEDAW Committee's reasoning expressly recognizes that individual instances of obstetric abuse are part of the broader problem of gender-based violence because such abuse erodes women's autonomy and ability to make decisions about their bodies. This innovation is important because abuse in obstetric and gynecological care, as a category of violence, often eludes lawmaking on violence against women. Naming obstetrics violence is important, as its invisibility could be tied to the historical devaluation of women. The disempowerment and lack of control that women, especially minority women, experience are magnified in cases involving pregnancy and fertility. Only a multifaceted feminist analysis, attentive to issues of race and power, can adequately expose obstetrics violence.

In the final analysis, the Article argues that the rise of telemedicine challenges states and all stakeholders to give greater attention to the human rights-based approach to the delivery of obstetric care. The definition of obstetric violence as a subset of gendered violence highlights that it is also a type of structural violence and, therefore, needs to be addressed systemically. In this line of inquiry, I follow Johan Galtung's introduction to the term structural violence, further illustrated by Paul Farmer who argued that "the arrangements are structural because they are embedded in the political and economic organization of our social world," and that they are violent because "they cause injury to people."[3]

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[1] Maria T.R. Borges, Note, *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, 67 DUKE L.J. 827, 829 (2018).
[2] *Id.*
[3] Paul E. Farmer ET AL., *Structural Violence and Clinical Medicine*, 3 PLOS MED. 1686, 1686 (2006) [https://perma.cc/F7FK-U8ZF].

INTRODUCTION

In this Article, I explore the phenomenon of forced sterilization and other types of obstetric violence within the context of human rights using a rights-based framework. Coined by Johan Galtung and popularized by health equity advocate, Paul Farmer, the concept of structural violence refers to societal structures encompassing economic, political, and legal realms that unjustly hinder individuals' fundamental human rights. By examining the interconnectedness of structural violence, obstetric violence, and forced sterilization, this Article aims to develop a justiciable framework for taking remedial action in accordance with human rights guarantees.

Drafted in 1999, General Recommendation 24 defines Article 12 of the Convention on the Elimination of Discrimination Against Women (CEDAW) and acknowledges that health is experienced within a given political, economic, and social context.[4] However, some have critiqued General Recommendation 24 for neglecting institutional structures of global health inequalities.[5]

Political and economic structures reproduce inequality that impacts reproductive health and rights. Gender inequality in health can be linked to structural conditions of economic and minority status. How can the CEDAW combat structural inequalities in transformative projects? Transforming these structural inequalities is key to health equity. In fact, the Preamble to the CEDAW reads: "The establishment of the new international economic order

[4] Committee on the Elimination of Discrimination Against Women [hereinafter CEDAW Committee], *General Recommendation No. 24: Article 12 of the Convention (Women and Health)* [hereinafter *General Recommendation No. 24*], ¶ 11, U.N. Doc. A/54/38/Rev., Chap. I (1999) [https://perma.cc/TQ8Y-7T27].

[5] FRONTIERS OF GENDER EQUALITY: TRANSNATIONAL LEGAL PERSPECTIVES 327 (Rebecca Cook ed., 2023).

based on equity and justice will contribute significantly towards the promotion of equality between men and women."[6] In light of this, any remedy regarding obstetrics violence and involuntary sterilization must be designed in a way that addresses the systems of power and control that led to the discrimination.

Violence against women is most often viewed and studied through the lens of interpersonal or physical violence. The US Violence Against Women Act, for instance, addresses only individual, behavioral acts of violence against women, such as domestic and dating violence, sexual assault, and stalking.[7] This characterization, however, is unduly narrow and excludes structural and institutional gender-based violence.

I argue that these two overarching forms of violence against women are interrelated: individual acts of violence, and structural and systemic violence. To combat the root causes of gender-based violence, it is essential to address both interpersonal and institutional violence against women.

Structural violence was first introduced as a concept in 1969 by Johan Galtung, a sociologist and founder of peace and conflict studies.[8] He urged society to reject the notion that violence is only "somatic incapacitation, or deprivation of health . . . at the hands of an actor who intends this to be the consequence."[9] Galtung's introduction to the term structural violence was not popularized until 2006 when Paul Farmer, a medical physician and anthropologist, expounded on the specific components of structural violence.[10] He noted that "the arrangements are *structural* because they are embedded in the political and economic organization of our social world," and that they are violent because "they cause injury to people."[11] Furthermore, his contextualization of the topic within the specific framework of the 2005 AIDS epidemic in Haiti helped society gain a more concrete understanding of the formerly theoretical concept.[12]

Galtung defined a triangle of violence—direct, structural, and cultural—as one which exists to influence and overlap with each

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[6] G.A. Res. 34/180, Convention on the Elimination of All Forms of Discrimination against Women [CEDAW] (Dec. 18, 1979).
[7] 42 U.S.C. 13925 (1994) [https://perma.cc/HG9S-RDRY].
[8] Johan Galtung, *Violence, Peace, and Peace Research*, 6 J. PEACE RSCH. 167, 173 (1969) [https://perma.cc/2VDM-QHZ9].
[9] *Id.* at 168.
[10] Paul E. Farmer ET AL., *Structural Violence and Clinical Medicine*, 3 PLOS MED. 1686, 1686 (2006) [https://perma.cc/F7FK-U8ZF].
[11] *Id.*
[12] *Id.*

other.[13] While direct violence is an act or threat of actual physical violence against another, structural violence is "exerted systematically—that is, indirectly—by everyone who belongs to a certain social order."[14] Social anthropologists Nancy Scheper-Hughes and Philippe Bourgois described structural violence as being "not deviant behavior, not disapproved of, but to the contrary is defined as virtuous action in the service of generally applauded conventional social, economic, and political norm."[15] Structural violence refers to policies, codes of behavior and structures that indirectly result in dehumanizing people. The general theory behind structural violence is inequality above all in the distribution of power. Galtung also examined the impact of structural violence on the mind and spirit, as well as the connection between structural violence and environmental destruction.[16] Scheper-Hughes and Bourgois also include "humiliation" in the list of harms caused by structural violence.[17] A combination of direct and structural violence often overlaps in what we define as gender-based violence.

Over half a century later, however, Galtung's seminal theories on structural violence have yet to be widely embraced in framing violence against women. Forced sterilization and obstetric violence, especially within an intersectional framework, are two forms of institutional violence that will be highlighted in this Article, followed by an examination of the applicable human rights framework for these evolving categories of gender-based violence within an intersectional lens.

I. FORCED STERILIZATION

Forced and involuntary sterilization infringes upon a woman's fundamental rights to bodily autonomy and reproductive decision-making. This encompasses cases of emotionally coerced sterilization, where power imbalances manipulate patients into giving consent, thereby undermining their autonomy. It is important to note that forced sterilization has been used against individuals affected by the Human Immunodeficiency Virus (HIV).

Government sterilization programs were initially established during the 1920s in Europe and the U.S., aligning with the eugenics movement.[18] These

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[13] Johan Galtung, *Cultural Violence*, 27 J. PEACE RESCH. 291, 294 (1990) [https://perma.cc/7ND9-8J6P].

[14] Paul E. Farmer, *An Anthropology of Structural Violence*, 45 CURRENT ANTHROPOLOGY 305, 307 (2004) [https://perma.cc/6GA8-GCB].

[15] NANCY SCHEPER-HUGHES & PHILIPPE BOURGOIS, VIOLENCE IN WAR AND PEACE: AN ANTHOLOGY 5 (2004).

[16] Galtung, *Cultural Violence*, *supra* note 12, at 294.

[17] Scheper-Hughes & Bourgois, VIOLENCE IN WAR AND PEACE, *supra* note 15, at 1.

[18] Pooja Nair, *Litigating Against the Forced Sterilization of HIV-Positive Women: Recent Developments in Chile and Namibia*, 23 HARV. HUM. RTS. J. 223, 223 (2010).

programs aimed to prevent specific marginalized communities from reproducing. In 1927, the U.S. Supreme Court upheld the constitutionality of a Virginia law that mandated sterilization for individuals with mental disabilities.[19] Justice Oliver Wendell Holmes infamously stated that it was preferable for society to prevent the propagation of those deemed unfit, rather than resorting to executing or neglecting their offspring.[20] The eugenics movement suffered a significant loss of credibility following World War II due to its association with Nazism. However, certain countries continued to use sterilization to address issues such as poverty, overpopulation, and the proliferation of minority groups.

In addition to its physical, psychological, and social harms, forced sterilization constitutes a violation of a woman's basic human rights as codified by the international community. Some international human rights documents establish general rights to integrity of the body and freedom to make reproductive choices, while others—including the Rome Statute of the International Crime Court (ICC)—specifically mention forced sterilization as a violation of human rights.[21] Despite international human rights guarantees, and the general medical practice of acquiring informed consent, forced sterilization remains a common practice in nations with high HIV rates.

A. Forced Sterilization of Roma Women

In 1971, the Communist Party of Czechoslovakia introduced a policy that legalized offering financial incentives to Romani women in exchange for sterilization.[22] This discriminatory approach aimed to control the Roma birth rate under the guise of promoting a healthier population.[23] While non-Roma women were financially incentivized to have children, Romani women were coerced into not giving birth.[24] Although this policy came to an end in 1993, it is estimated that by 1988, the Communist party

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[19] Buck v. Bell, 274 U.S. 200, 200 (1927) [https://perma.cc/FJ4W-EB3M].
[20] *Id.* at 207.
[21] Int'l Crim. Ct., Rome Statute of the International Criminal Court, art. 7 (2021), https://www.icc-cpi.int/sites/default/files/RS-Eng.pdf (categorizing forced sterilization as a crime against humanity, alongside "rape, sexual slavery, enforced prostitution, [and] forced pregnancy") [https://perma.cc/T8SK-MCPP].
[22] Gwendolyn Albert & Marek Szilvasi, *Intersectional Discrimination of Romani Women Forcibly Sterilized in the Former Czechoslovakia and Czech Republic*, HEALTH AND HUM. RTS. J., 5 (Dec. 4, 2007), https://www.hhrjournal.org/2017/12/intersectional-discrimination-of-romani-women-forcibly-sterilized-in-the-former-czechoslovakia-and-czech-republic/ [https://perma.cc/9CGE-43WE].
[23] *Id.* at 6.
[24] *Id.*

gave Roma women a sum of 1.5 million dollars in rewards in exchange for undergoing sterilization.[25]

In the case of *VC v. Slovakia* before the European Court of Human Rights (ECHR), a significant judgment was reached on November 8, 2011.[26] V.C., a Romani woman, underwent a cesarean section at an Eastern Slovakian state hospital.[27] Disturbingly, during her labor, the hospital staff insisted that she sign a consent form for sterilization, yet provided insufficient information about the procedure.[28] Fearing for her life, V.C. signed the form without comprehending its implications, being informed only of the potential risks to future pregnancies.[29] Later realizing that the sterilization was unnecessary, V.C. pursued a civil lawsuit in Slovakia, but her appeals were rejected.[30] Subsequently, V.C. brought her case to the ECHR.[31] The court held in favor of V.C., ruling that sterilization cannot be performed without the full and informed consent of the patient, even if doctors believe that future pregnancy may pose a risk to a woman.[32] The court concluded that the forced sterilization of V.C. constituted inhuman and degrading treatment in violation of Article 3 of the ECHR, and that the forced sterilization interfered with V.C.'s right to private and family life under Article 8 because it permanently affected her reproductive capacity without her full understanding and consent.[33]

Another Roma woman, A.S., brought a similar case against Hungary. Prior to an emergency caesarian section, A.S. was asked by a doctor to sign consent forms that included a handwritten statement indicating her consent to a sterilization procedure.[34] A.S. was unaware of the sterilization provision and only learned about it after the operation. Her claims of civil rights violations and negligent sterilization were rejected at the local level. In her communication to the CEDAW Committee, it was determined that A.S. had exhausted her domestic remedies, as Hungarian law did not allow her to appeal the decision to the Constitutional Court due to the specific nature of

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[25] Da Won (Amy) Shin, *The Forced Sterilization of Romani Women: A Genocide Under Cover*, CONNECT IN HEALTH (May 22, 2019), https://www.connectinhealth.org/post/the-forced-sterilization-of-romani-women-a-genocide-under-cover [https://perma.cc/ZG69-TSCC].

[26] V.C. v. Slovakia., 2011-V EUR. CT. H.R., App. No. 18968/19. ¶ 7 (Aug. 2, 2012), https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-107364%22]} [https://perma.cc/5PRR-HGKN].

[27] *Id.* at ¶ 9.

[28] *Id.* at ¶ 14.

[29] *Id.* at ¶ 15.

[30] *Id.* at ¶ 27.

[31] *Id.* at ¶ 41.

[32] *Id.* at ¶ 131.

[33] *Id.* at ¶ 120, 155.

[34] A.S. v. Hungary, Communication No. 4/2004, 3 CEDAW/C/36/D/4/2004 [https://perma.cc/W6BP-4YJY].

her case. Hungary was found to have violated A.S.'s right to fully informed consent to medical procedures, the right to information on family planning, the right to appropriate services during pregnancy and the post-natal period, and the right to determine the number and spacing of her children under Articles 10(h), 12, and 16(1)(e) of the CEDAW. The Committee considered the communication admissible despite the fact that the operation occurred before the Optional Protocol entered into force for Hungary. This was because sterilization was viewed as a continuous injury, with low chances of successful reversal and irreversible consequences, contrary to the state's claims.

In a letter addressed to Slovak Prime Minister Eduard Heger, Dunja Mijatović, the Commissioner for Human Rights of the Council of Europe, emphasized the urgent need for the Slovak government to establish a rapid and efficient compensation mechanism for women who had been subjected to forced sterilization.[35] While acknowledging the initial step of offering apologies to the victims, Mijatović expressed her expectation for swift progress in implementing an accessible and effective compensation system for the victims.[36] In response, Slovak Justice Minister Mária Kolíková assured the Council of Europe Commissioner that the Slovak government is committed to addressing the issue and compensating the victims of forced sterilization.[37]

B. Forced Sterilization of HIV-Positive Women

In another modern incarnation of sterilization, some countries with high rates of HIV use forced sterilization to prevent mother-to-child HIV transmission. In an attempt to combat the HIV epidemic in Chile, the

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[35] Letter from Dunja Mijatović, Commissioner for Human Rights, Council of Europe, to Eduard Heger, Prime Minister, Slovak Republic & Mária Kolíková, Minister of Justice, Slovak Republic (July 12, 2021), https://polit-x.de/de/documents/6535596/europa/englisch/council-of-europe/documents-2021-07-19-letter-to-mr-eduard-heger-prime-minister-of-the-slovak-republic-and-ms-maria-kolikova-by-ms-dunja-mijatovic-council-of-europe-commissioner-for-human-rights-concerning-the-situation-of-victims-of-forced-or-coercive-sterilisations [https://perma.cc/BT5X-PLCB].

[36] *See* @CommissionerHR [Dunja Mijatović], TWITTER, (Nov. 24, 2021, 1:04 PM), https://twitter.com/CommissionerHR/status/1463569227051421697 [https://perma.cc/AJZ4-GRPB] ("I welcome the news of Slovak Government's apology to victims of forced sterilisation as a first important step. I now look forward to quick progress on an accessible & effective compensation mechanism.").

[37] Letter from Mária Kolíková, Minister of Justice, Slovak Republic to Dunja Mijatović, Commissioner for Human Rights, Council of Europe (July 15, 202[1]), https://rm.coe.int/reply-of-ms-maria-kolikova-minister-of-justice-of-the-slovak-republic-/1680a33c17 [https://perma.cc/GAK5-59EP].

government implemented a distressing policy of forcibly sterilizing HIV-positive women.[38] A 2004 study conducted by Vivo Positivo, Universidad Arcis, and Facultad Latinoamericana de Ciencias Sociales revealed that nearly forty-two percent of HIV-positive women who underwent sterilization were deprived of their right to give informed consent.[39] This practice highlights a grave violation of human rights and raises urgent concerns about the protection and autonomy of HIV-positive women in Chile.

A notable case surrounding the forced sterilization of an HIV-positive woman, F.S., was brought before the Inter-American Commission on Human Rights (IACHR) by the Center for Reproductive Health and Vivo Positivo in Chile.[40] After a protracted legal battle within the Chilean courts, Vivo Positivo and the Center for Reproductive Rights pled to the IACHR, seeking Chile's acknowledgment that F.S.'s human rights had been violated, financial compensation for F.S., and the implementation of policies that respect the reproductive choices of women living with HIV.[41] As a result, the Chilean government entered into a friendly agreement with the petitioner, acknowledging the harm caused to F.S., who was forcibly sterilized after giving birth to her son in 2002.[42] The agreement also established a monitoring mechanism, enabling the Center and Vivo Positivo to ensure the compliance with the commitments made by the Chilean State.[43] This case sheds light on discrimination against people living with HIV/AIDS in Chile and other parts of Latin America, including the violation of their human rights through forced sterilization.

In an earlier groundbreaking case before the IACHR, Peru acknowledged its responsibility for the forced sterilization of María Mamérita Mestanza Chávez (M.M.M.C.), which resulted in her subsequent death due to inadequate healthcare.[44] M.M.M.C. underwent tubal ligation after facing threats of

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[38] Nair, *supra* note 18, at 227.

[39] Francisco Vidal & Marina Carrasco, MUJERES CHILENAS VIVIENDO CON VIH/SIDA: ¿DERECHOS SEXUALES Y REPRODUCTIVOS?: UN ESTUDIO DE CORRELACIONES EN OCHO REGIONES DEL PAÍS [CHILEAN WOMEN LIVING WITH HIV/AIDS: WHAT ARE THEIR SEXUAL AND REPRODUCTIVE RIGHTS?: A STUDY OF CORRELATIONS IN EIGHT REGIONS OF THE COUNTRY] 93 (Universidad Arcis, 2004), http://www.feim.org.ar/pdf/blog_violencia /chile/MujeresChilenas_con_VIH_y_DSyR.pdf (describing that 12.9 percent of sterilized HIV-positive women in Chile underwent the procedure without their consent and 29 percent agreed to sterilization under coercion from hospital staff) [https://perma.cc/8SY3-2RM5].

[40] F.S. v. Chile, Petition 112-09, Inter-Am. Comm'n H.R., Report No. 52/14, OEA/Ser.L/V/II.151, doc. 17 ¶ 1 (July 21, 2014) [https://perma.cc/VL2E-P3AL].

[41] *Id.* at ¶ 28.

[42] Press Release, Ct'r for Reproductive Rgts., *Forcibly Sterilized Woman Files Int'l Case against Chile* (Feb. 3, 2009), http://reproductiverights.org/en/press-room/forcibly-sterilized-womanfiles-international-case-against-chile [https://perma.cc/8QU7-VUGW].

[43] *Id.*

[44] María Mamérita Mestanza Chávez v. Peru, Petition 12.191, Inter-Am. Comm'n H.R., Report No. 71/03, ¶ 14 (Oct. 22, 2003) [https://perma.cc/Q4N5-SZN7].

criminal sanctions from Peruvian health officials if she did not undergo sterilization.[45] She did not receive any pre- or post-procedure healthcare, nor was she informed about the potential complications or risks associated with the procedure. After a series of complications, she passed away in her home nine days after the procedure.[46] Peru committed to implementing the recommendations put forth by the country's Human Rights Ombudsperson, specifically addressing forced sterilization of women.[47] The government also agreed to provide compensation to the family members of the victims and revise policies on reproductive health and family planning based on the principles of nondiscrimination.[48] In recent years, former Peruvian President Alberto Fujimori and several former health ministers were charged with the forced sterilization of thousands of women between 1990 and 2000.[49] The sterilization program had been introduced as part of an anti-poverty drive, aimed at cutting birth rates among poor families.[50]

Forced and coerced sterilization is a pervasive issue in Namibia, with a distressing investigation revealing that out of 230 women living with HIV, 40 had been subjected to non-consensual sterilization.[51] Shockingly, these women were coerced into signing forms during intensely vulnerable moments, such as while on the verge of giving birth.[52] These accounts expose a distressing reality where patients were denied the ability to make well-informed decisions about their medical care.[53] This power dynamic poses grave dangers, as it can discourage HIV-positive women from seeking necessary medical attention, thus increasing the risk of HIV transmission.[54] Compounding the suffering, these women face a lifetime of public disdain due to the societal stigma associated with sterilization in Namibia.[55]

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[45] *Id.* at ¶ 9-10.
[46] *Id.* at ¶ 11-12.
[47] *Id.* at ¶ 14.
[48] *Id.*
[49] *New Charges Pressed Against Alberto Fujimori for Atrocious Crimes*, MERCOPRESS (Dec. 13, 2021, 08:53 UTC), https://en.mercopress.com/2021/12/13/new-charges-pressed-against-alberto-fujimori-for-atrocious-crimes [https://perma.cc/2H76-CLU3].
[50] *Id.*
[51] *The Forced and Coerced Sterilization of HIV Positive Women in Namibia*, Int'l Cmty. of Women Living With HIV/AIDS (ICW), 7-12 (Mar. 2009), http://www.icw.org /files/The %20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20Namibia%2009.pdf.
[52] *Id.*
[53] *Id.*
[54] U.N. Programme on HIV/AIDS, *Confronting Discrimination: Overcoming HIV-Related Stigma and Discrimination in Health-Care Settings and Beyond* (2017), https://www.unaids.org /sites/default/ files/media_asset/confronting-discrimination_en.pdf.
[55] *Id.*

The International Community of Women Living with HIV/AIDS (ICW) and the Legal Aid Centre joined forces to file a total of fifteen cases against the Katutura State, Windhoek Central, and Oshakati hospitals.[56] The initial two cases brought before the High Court of Namibia centered around alleged violations of the victims' fundamental rights to life and human dignity.[57] At the core of these legal battles was the interpretation of "consent."[58] While the government contended that the mothers provided written consent for the sterilization procedure and that the mechanisms for ensuring informed consent were sufficient, the victims vehemently disputed this claim.[59]

In a significant development, in 2014, the Supreme Court of Namibia upheld the High Court's ruling, confirming that medical personnel at public hospitals violated the rights of three HIV-positive women by performing sterilizations without their consent.[60] The Namibian constitution explicitly guarantees every citizen the right to bodily integrity and the right to form a family.[61] Alongside arguing that their sterilizations were unlawful, the women claimed that the sterilizations were conducted based on their HIV status and infringed upon their right to be free from discrimination.[62]

When the government appealed the High Court's decision, the central legal question was whether the women gave their informed consent to undergo sterilization. Though the women signed consent forms in all three cases, they argued that their signatures were obtained under coercion and that they were not provided with adequate information.[63] However, the government argued that this was immaterial, asserting that the High Court only needed to consider whether the women were aware that sterilization results in sterility.[64]

The Supreme Court underscored the significance of a decision to be sterilized, emphasizing that it must be "made with informed consent, as opposed to merely written consent."[65] The Court reiterated that a woman must possess

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[56] Wezi Tjaronda, *Sterilisation Cases Headed for Courts*, NEW ERA LIVE (Apr. 7, 2008), https://neweralive.na/posts/sterilisation-casesheaded-for-courts.

[57] Republic of Namib. v. L.M., [2014] SA 49/2012 2 (Namib.) [https://perma.cc/5VYZ-DB68].

[58] *Id.* at 5.

[59] *Id.* at 5, 71.

[60] *Id.* at 75.

[61] CONSTITUTION OF THE REPUBLIC OF NAMIBIA, art. 14 (1990) (Namib.) ("Men and women of full age, without any limitation due to race, colour, ethnic origin, nationality, religion, creed or social or economic status shall have the right to marry and to found a family."). [https://perma.cc/GY4C-PPUE].

[62] Republic of Namibia v L.M., *supra* note 57, at 3.

[63] *Id.* at 68.

[64] *Id.* at 3.

[65] *Id.* at 5 ("Informed consent implies an understanding and appreciation of one's rights and the risks, consequences and available alternatives to the patient. An individual must also be able to make a decision regarding sterilisation freely and voluntarily.").

the intellectual and emotional capacity to provide informed consent in the particular circumstances in which she finds herself when signing the consent forms.[66] The Court noted that the records for all three women did not indicate the information conveyed to them during the process of obtaining their written consent.[67]

The Court rejected the concept of medical paternalism and emphasized the cardinal principles of individual autonomy and self-determination in shaping the legal framework.[68] This landmark decision holds significant implications for women living with HIV across Africa.

C. Forced Sterilization of Indigenous Women

Forced sterilization of Indigenous women in public hospitals in Canada has been documented from as early as the 1800s and as recently as 2019.[69, 70] It is estimated that more than 1,150 Indigenous women were forcibly sterilized across Canada between 1966 and 1967.[71] In 2017, two Indigenous women in Saskatchewan filed a class action suit for sterilization without consent. Growing media coverage resulted in over 100 other Indigenous women across multiple provinces coming forward with similar reports of sterilization without their free and informed consent.[72] The Saskatoon Health Region formally apologized to Indigenous women who were coerced into surgery and acknowledged the inequities in the healthcare system.[73]

The International Justice Resource Center (IJRC) partnered with these women to bring justice and redress, as well as advocate the cessation of

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[66] *Id.* at 70.
[67] *Id.* at 78.
[68] *Id.* at 76.
[69] Amnesty Int'l, *Amnesty International Submission to Standing Senate Committee on Human Rights Study on Sterilization without Consent*, SENATE OF CANADA, (Apr. 1, 2019), https://sencanada.ca/content/sen/committee/421/RIDR/Briefs/AmnestyInternational_Brief_e.pdf [https://perma.cc/FQC4-74LH].
[70] *Forced Sterilization*, NATIVE WOMEN'S ASS'N OF CAN., https://nwac.ca/ policy/forced-sterilization (last visited July 6, 2023) [https://perma.cc/PZ6X-84NY].
[71] Jennifer Leason, *Forced and Coerced Sterilization of Indigenous Women*, 67 CANADIAN FAM. PHYSICIAN 525, 525 (2021) [https://perma.cc/ZQ6S-MJK3].
[72] Amnesty Int'l, *supra* note 69.
[73] Betty Ann Adam, *Saskatoon Health Region Apologizes for Forced Tubal Ligations, says Report 'Provides Clear Direction*', SASKATOON STARPHOENIX (July 28, 2017), https://thestarphoenix.com/news/local-news/saskatoon-health-region-apologizes-for-forced-tubal-ligations-says-report-provides-clear-direction [https:// perma.cc /8A A Z-RVM6].

forced sterilization of Indigenous women in public hospitals.[74] The IJRC and partners spoke before the IACHR on the topic of forced sterilization, detailing experiences of the victims and recommending specific government action to stop future forced sterilizations.[75] The IACHR expressed its deep concern over the claims and urged Canada to "guarantee effective access to justice for survivors and their families."[76]

In 2018, the U.N. Committee Against Torture (CAT) called for the Canadian government to ensure the investigation of all claims of forced or coerced sterilization, provide redress to victims, and adopt legal measures to prevent and criminalize forced sterilization.[77] The CAT specifically recommended the implementation of legislative and policy measures, which include "clearly defining the requirement for free, prior and informed consent with regard to sterilization and….raising awareness among indigenous women and medical personnel of that requirement."[78]

The next year, Dainius Pūras, the then-Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, also discussed the forced sterilizations of Indigenous women in his report to the HRC following his visit to Canada.[79] The Special Rapporteur endorsed the CAT's recommendations, further noting that at least sixty Indigenous women had made similar allegations of forced or coerced sterilization, "including that their 'consent' to be sterilized had been obtained during or immediately after giving birth, through coercive means and often without information about alternative birth-control methods."[80] In addition, the then-Special Rapporteur on Violence Against Women, Its Causes and

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[74] *Forced Sterilization of Indigenous Women in Canada*, INTERNATIONAL JUSTICE RESOURCE CENTER, https:// ijrcenter.org /forced-sterilization -of-indigenous-women -in- canada/ [https://perma.cc/4V5D-RTCM].

[75] *Id.*

[76] Press Release, *IACHR Expresses Its Deep Concern Over the Claims of Forced Sterilizations Against Indigenous Women in Canada*, IACHR Press and Communication Office (Jan. 18, 2019), https://www.oas.org/en/iachr/media_center/PReleases/2019/010.asp [https://perma.cc/NQJ3-YSNV].

[77] U.N. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Committee against Torture [CAT], *Concluding Observations on the Seventh Periodic Report of Canada*, ¶ 50, U.N. Doc. CAT/C/CAN/CO/7 (Dec. 21, 2018) [https://perma.cc/5SYZ-7SNZ].

[78] *Id.* at ¶ 51(b).

[79] Dainius Pūras (Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health), *Rep. on Visit to Canada*, ¶ 83, U.N. Doc. A/HRC/41/34/Add.2 (June 19, 2019) [https://perma.cc/Q53T-8VV4].

[80] *Id.* at ¶ 83-84.

Consequences, Dubravka Šimonović, called for further investigation of forced sterilization of Indigenous women.[81]

In 2021, the Canadian Standing Senate Committee on Human Rights published a report detailing forced and coerced sterilizations in Canada.[82] In the report, the committee recommended the Canadian government respond to the report "without delay" and that a parliamentary committee conduct further studies on forced sterilizations with the goal of "identifying solutions to stop the practice."[83]

D. What is Informed Consent?

To prevent the harm associated with unwanted physical invasions, medical professionals developed the doctrine of informed consent. This doctrine requires that patients give their consent to all surgical procedures and have a clear understanding of the procedures and their potential consequences before providing consent.

The American Medical Association (AMA) recognizes informed consent as both an ethical obligation and a legal requirement.[84] It emphasizes that informed consent is not merely obtaining a patient's signature on a consent form; healthcare professionals should ensure that patients fully comprehend the nature of the medical procedure.[85] Regarding sterilization, Family Health International highlights that, due to its surgical and permanent nature, voluntary sterilization demands heightened care from healthcare

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[81] Dubravka Šimonović (Special Rapporteur on Violence against Women), *Rep. on Visit to Canada*, ¶ 61, U.N. Doc. A/HRC/41/42/Add.1 (Nov. 4, 2019) [https://perma.cc/97XD-HS9D].

[82] Standing Senate Committee on Human Rights, *Forced and Coerced Sterilization of Persons in Canada* (June 2021), https://sencanada.ca/content/sen/committee/432/ RIDR/ reports/ForcedSterilization_Report_FINAL_E.pdf [https://perma.cc/5WUQ-WA9X].

[83] *Id.* at 28.

[84] AM. MED. ASS'N, *AMA Code of Medical Ethics: Informed Consent*, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent (last visited Nov. 13, 2023) ("Informed consent to medical treatment is fundamental in both ethics and law.") [https://perma.cc/XS78-Q7QB].

[85] *Id.* ("The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent. . . physicians should: Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision. . . . Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. . . . The physician should include information about: the diagnosis (when known); the nature and purpose of recommended interventions; the burdens, risks, and expected benefits of all options, including forgoing treatment.") [https://perma.cc/9VJK-4QEM].

providers compared to other contraceptive methods.[86] Any form of coercion, whether physical or emotional, violates the requirement for informed consent in sterilization procedures. Despite the fact that informed consent clearly precludes the existence of coercion or force, poor minority women are often pressured to undergo sterilization.[87]

Informed consent is more than simply signing a consent form; it is the *mutual sharing of information* among a range of caregivers to facilitate the active engagement of women in their treatment. U.S. Supreme Court Justice Cardozo's early articulation of the principle reflected the core concern of informed consent—procuring individual autonomy.[88] However, this articulation is couched in gendered pronouns:[89] "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, from which he is liable in damages."[90]

While the possibility of litigation can incentivize policy change and foster governmental respect for reproductive choices, forced sterilization remains a prevalent issue in Latin America and Africa, indicating that more work needs to be done to address this problem effectively.

II. OBSTETRIC VIOLENCE

Obstetric violence has long been a site of structural violence. It is only in recent years that the global women's human rights movement has attempted to incorporate into its legal framework a recognition of a historic form of gender-based violence involving the mistreatment and abuse of

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[86] Lynn Bakamjian & Pamela Beyer Harper, *Opinion: Voluntary Sterilization—Six Lessons Learned*, 18 NETWORK (1997), http://www.fhi.org/en/RH/Pubs/Network/v18_1/NW181ch7.htm [https://perma.cc/DW22-8ZHV].

[87] Priti Patel, *Forced Sterilization of Women as Discrimination*, 38 PUB. HEALTH R., July 14, 2017, at 1, 1 [https://perma.cc/X4PA-UZ6A].

[88] Schloendorff v. Soc'y of New York Hosp., 105 N.E. 92, 92 (N.Y. 1914) [https://perma.cc/D3D7-WXE7].

[89] The U.S. has a long history of state-sanctioned forced sterilization of poor women, disabled women, and women of color beginning from the late 1800s to as recently as September 2020. In 1927, the Supreme Court ruled that a state law authorizing the forced sterilization of inmates in mental institutions was constitutional. Native American, Black, and Hispanic women were disproportionately targeted by such policies. In the 1960s, Black women made up sixty-five percent of all sterilizations of women despite comprising only twenty-five percent of the population. The Indian Health Service was accused of sterilizing nearly a quarter of Indigenous women in the 1960s and 1970s. As recently as 2017, the criminal legal system offered forced sterilization in exchange for a sentence in reduction. Sanjana Manjeshwar, *America's Forgotten History of Forced Sterilization*, BERKELEY POLITICAL REVIEW (Nov. 4, 2020), https://bpr.berkeley.edu/2020/11/04/americas-forgotten-history-of-forced-sterilization/ [https://perma.cc/KG9R-5RVS].

[90] *Schloendorff*, 105 N.E. 92 at 93.

pregnant and birthing women. The 1994 International Conference on Population and Development Programme of Action unequivocally declared that reproductive rights are human rights and shaped jurisprudence that recognized reproductive rights at the intersection of compounded forms of human rights violations.[91]

The term *obstetric violence* acknowledges that individual instances of obstetric abuse are part of a broader context of gender-based violence, as they infringe upon women's autonomy and their ability to make decisions freely about their bodies and sexuality.[92] It is crucial to recognize the potential of obstetric violence to reveal previously unacknowledged harm. Abuse in obstetric and gynecological care is often overlooked in laws addressing violence against women or gender-based violence. Moreover, defining obstetric violence as a subset of gendered violence highlights that it is a form of structural discrimination which requires systemic measures to address it effectively.

The World Health Organization (WHO) acknowledges that many women worldwide experience disrespectful, abusive, or neglectful treatment during childbirth in healthcare facilities.[93] Obstetric violence encompasses violations of rights to informed consent and bodily autonomy, leading to physical, psychological, and emotional harm. Perpetrators of mistreatment during childbirth can include healthcare professionals as well as other staff involved in labor and delivery, with power dynamics often influencing these interactions.

It is worth noting that there is no universally recognized definition of obstetric violence within global public health discourse. CEDAW's categorization is not exhaustive and provides a flexible continuum. Although obstetric violence encompasses a wide range of practices, there is significant overlap between abusive, coercive, and disrespectful treatment. Therefore, the categorization put forth by the CEDAW Committee implicitly recognizes that many incidents reported by women involve multiple forms of conduct that, collectively, may qualify as violence.

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[91] U.N. Dep't of Econ. & Soc. Affairs, *Programme of Action Adopted at the International Conference on Population and Development*, Cairo, 5-13 September 1994, U.N. Doc. ST/ESA/SER.A/149, Sales No. E.95XIII.7 (1995) [https://perma.cc/Z5Z3-LKD4].

[92] Sara Cohen Shabot, *We Birth with Others: Towards a Beauvoirian Understanding of Obstetric Violence*, 28 EUR. J. WOMEN'S STUD. 213, 214 (2021).

[93] World Health Organization [WHO], *In the Prevention and Elimination Of Disrespect and Abuse During Facility-Based Childbirth* (2015), http://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/ [https://perma.cc/E2UH-L7WP] (advocating a plan to prevent "disrespectful, abusive, or neglectful treatment" that over ninety organizations endorsed) [https://perma.cc/E2UH-L7WP].

The discourse surrounding obstetric violence has gained traction in scholarly circles, particularly within the U.S. However, the majority of references to obstetric violence primarily focus on developments occurring outside the U.S. Inspired by advocates in Latin America who have directly addressed the problem of mistreatment during childbirth and, in certain jurisdictions, successfully obtained legal measures against such behavior, advocates worldwide have started adopting the term "obstetric violence" to characterize and denounce these forms of abuse.[94]

Latin America has emerged as a leading force in the pursuit of legal remedies for victims of obstetric violence. The concept of "obstetric violence" was initially developed by grassroots movements in various Latin American countries during the early 2000s.[95] These movements were prompted, in part, by the substandard birthing conditions prevalent in Latin American hospitals, earning the region a reputation as the epicenter of an obstetric violence epidemic. Brazil played a pivotal role in shaping the discourse on obstetric violence, with the establishment of the Network for the Humanization of Labor and Birth (ReHuNa) in 1993.[96] ReHuNa acknowledged the various forms of violence and mistreatment occurring within women's reproductive healthcare. In 2000, Brazil hosted the First International Conference for the Humanization of Birth, a significant event dedicated to addressing the high rates of childbirth interventions and the associated abuses.[97] More recently, Brazil's Ministry of Health initiated a program to train doctors in teaching hospitals, emphasizing the importance of women's rights within the field of obstetrics.[98]

Venezuela became the first country to officially define *obstetric violence* in 2007 when it enacted a comprehensive legal framework to

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[94] *See* Kelsey M. Jost-Creegan, *Debts of Democracy: Framing Issues and Reimagining Democracy in Twenty-First Century Argentine Social Movements*, 30 HARV. HUM. RTS. J. 165, 201 (2017) (mentioning obstetric violence in the context of the Argentine dictatorship's impact on women's reproductive health); Liiri Oja & Alicia Ely Yamin, *"Woman" in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?*, 32 COLUM. J. GENDER & L. 62, 79 (2016) (noting the use of the term "obstetric violence" throughout Latin America) [https://perma.cc/MA49-Y72Z].

[95] Lola Favre, *South American Legislation Against Obstetric Violence: Results from Early Mobilisation*, Gender in Geopolitics Inst. (July 22, 2020), https://igg-geo.org/?p=1648&lang=en.

[96] Carmen Simone Grilo Diniz ET AL., *Disrespect and Abuse in Childbirth in Brazil: Social Activism, Public Policies and Providers' Training*, 26 REPRODUCTIVE HEALTH MATTERS 19, 20 (2018) [https://perma.cc/C42H-GGTW].

[97] Lesley Ann Page, *The Humanization of Birth*, 75 INT'L J. OF GYNECOLOGY & OBSTETRICS, S55, S55 (Nov. 2001).

[98] Roosa Tikkanen et al., *International Health System Profiles: Brazil*, Commonwealth Fund (June 5, 2020), https://www.commonwealthfund.org/ international -health- policy-center/countries/brazil [https://perma.cc/3ZEP-XX22].

safeguard the "right of women to a life free of violence." [99] This framework describes "obstetric violence" as the appropriation of women's bodies and reproductive processes by healthcare personnel, resulting in dehumanizing treatment and an abuse of medication.[100] Moreover, it acknowledges that the pathologization of childbirth through obstetric violence leads to a loss of patient autonomy. Autonomy entails the ability for women to make decisions freely regarding their bodies and sexuality, and such a loss of autonomy ultimately diminishes women's quality of life.[101] Venezuelan law criminalizes several forms of obstetric violence, such as performing cesarean sections and artificially accelerating labor without informed and voluntary consent.[102]

Following Venezuela's lead, Argentina enacted two laws to address obstetric violence. The first, passed in 2004, advocated for "humanized childbirth" and emphasized the rights of women, newborns, birth companions, and families.[103] In 2009, Argentina passed a complementary law establishing penalties for gender-based violence and included a specific provision addressing obstetric violence.[104] Similar to Brazil, Argentina also implemented a program to educate healthcare workers about the importance of women's rights in obstetric medicine, resulting in a decrease in infant and maternal mortality rates. Other countries in Latin America, such as Mexico, Bolivia, and Panama have also made efforts to address obstetric violence within their legal frameworks.[105]

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[99] Ley Organica sobre el Derecho de las Mujeres a una Vida Libre de Violencia (Organic Law on the Right of Women to a Life Free of Violence), VEN102784.E (Venez.) [https://perma.cc/24M6-L7TE].

[100] *Id.* at art. 51 (identifying specific acts that constitute obstetric violence, including untimely and ineffective responses to obstetric emergencies, unnecessary augmentation of low-risk labor and birth, and performing cesarean sections without obtaining voluntary, expressed, and informed consent from the woman).

[101] *Id.*

[102] Sara Fernández Rivera, *Analysis of the Venezuelan Reform of the Organic Law on Women's Right to a Life Free of Violence of 2021*, Acceso a la Justicia (2022), https://accesoalajusticia.org/wp-content/uploads/securepdfs/2022/07/Analysis-of-the-venezuelan-reform-of-the-organic-law-on-womens-right-to-a-life-free-of-violence-of-2021.pdf [https://perma.cc/VDU3-8H46].

[103] Law 25,929, Ministerio de Justicia y Derechos Humanos (Sept. 17, 2004), http://servicios.infoleg.gob.ar/infolegInternet/anexos/95000-99999/98805/norma.htm [https://perma.cc/8XGR-CYLC].

[104] Florencia Daniela Binci Mauri & María Paula Croatto Massi, *Abortion as Obstetric Violence* (Jan. 2022), https://aul.org/wp-content/uploads/2022/02/Abortion-as-Obstetric-Violence.pdf (describing Law 26,485's definition of obstetric violence as "that which a healthcare worker exerts on the body and reproductive processes of women, resulting in dehumanized treatment, an abuse of medicine and perversion of natural processes, in accordance with Law 25929") [https://perma.cc/3K2R-VZJC].

[105] Rodante van der Waal et al., *Obstetric Violence: An Intersectional Refraction through Abolition Feminism*, 4 Feminist Anthropology 91, 95 (2023).

The core argument in this Article is that obstetric violence is part of a broader context of structural violence against women. The Venezuelan law criminalizes several categories of obstetric violence. Firstly, there is the performance of cesarean sections without the informed and voluntary consent of the patient. Another issue is the practice of artificially speeding labor without informed and voluntary consent. Globally, these are the twin procedures that women are coerced to undergo. The medicalization of childbirth is linked to the growing pathologization of pregnancy.

As explained above, Venezuela and Argentina introduced new legal concepts that classify abuse and disrespect during pregnancy and childbirth as obstetric violence. These legal frameworks are premised on a definition of obstetric violence as dehumanizing treatment that undermines women's ability to decide freely about their bodies and negatively impacts women's quality of life.

While Argentina has not criminalized the conduct, Venezuela has used this concept to criminalize particular circumstances of obstetric violence, as well as to oversee public policies drafted to reduce gendered violence in the country.

Similarly, the Women's Global Network for Reproductive Rights defines obstetric violence as a type of institutional, gender-based violence directed at women during pregnancy, childbirth, and postpartum recovery.[106]

Although the term obstetric violence often eludes discourse on gender-based violence, the WHO has recognized that "many women experience disrespectful and abusive treatment during childbirth."[107] Burgeoning medical interventions designed to aid women during childbirth have given rise to a situation where new technologies are used against a woman's will often to expedite the birthing process. These instances commonly encompass situations where women are subjected to forced cesarean sections against their preference for a natural birth, undesired episiotomies, unnecessary administration of epidurals, or improper use of vacuum extraction or forceps. The widespread occurrence of such interventions contributes to a systemic problem of obstetric violence, resulting in physical, psychological, and emotional harm for both birthing women and their newborns. In a study examining birthing outcomes in Sri Lanka, it was found that 18.1% of women reported experiencing obstetric violence perpetrated by healthcare providers

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[106] Camilla Pickles, *Reflections on Obstetric Violence and the Law: What Remains to be Done for Women's Rights in Childbirth?*, UNIV. OXFORD FAC. L. BLOGS (Mar. 8, 2017), https://blogs.law.ox.ac.uk/research-and-subject-groups/international-womens-day/blog/2017/03/reflections-obstetric-violence-and.

[107] WHO*, The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth* (2015), https://apps.who.int/iris/bitstream/handle/10665/134588 /WHO_RHR _14.23_eng.pdf [https://perma.cc/3CZ6-X492].

during their most recent pregnancy.[108] Additionally, nearly all of these women categorized such violence as a form of emotional obstetric violence.[109]

During the early stages of obstetric medicine, the medical profession adopted a model based on the male body, considering it as the norm against which the female body was compared. In a society that places women in a subordinate position, reproductive health processes specific to females, including menstruation, pregnancy, and menopause, have been and continue to be regarded as abnormalities, diseases, or deviations. The occurrence of childbirth further complicates the issue of sexism within healthcare, as the female body becomes a locus of control during the birthing process, where the body is viewed primarily as a vessel for childbirth. The historical mistreatment, control, and lack of respect toward birthing women have played a role in perpetuating patriarchal control over women's bodies.

While the term *obstetric violence* is not yet universally recognized in global public health discourse, various States, scholars, human rights frameworks, and treaty bodies increasingly recognize obstetric violence as its own, distinct form of violence against women.[110] The U.N. Special Rapporteur on health and the Special Rapporteur on cruel, inhuman, and degrading treatment, for example, have linked abuse of pregnant women seeking reproductive health care to women's "unnecessary suffering on the basis of gender."[111] In 2019, Dubravka Šimonović, the Special Rapporteur on Violence against Women ("VAW"), presented her report to the U.N. General Assembly on "mistreatment and VAW during reproductive health services with a focus on childbirth and obstetric violence."[112] A careful understanding of the structural factors that underlay obstetric violence can inform the

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[108] Dinusha Perera ET AL., *Obstetric Violence Is Prevalent in Routine Maternity Care: A Cross-Sectional Study of Obstetric Violence and Its Associated Factors among Pregnant Women in Sri Lanka's Colombo District*, 19 INT'L J. OF ENV'T RSCH. & PUB. HEALTH 9997, 9999 (2022).

[109] *Id.*

[110] *Gynecological and Obstetric Violence*, IPPF European Network (July 2022), https://europe.ippf.org/sites/europe/files/2022-11/Gynaecological%20and%20Obstetric%20Violence_IPPF%20EN%20Policy%20Paper.pdf (Several Central and Latin American countries such as Chile, Brazil and Bolivia, followed the example of Venezuela, Argentina, and several States within Mexico. In Europe, only the Catalonia region in Spain has adopted a law defining obstetric violence within its law on sexist violence that includes forced sterilization, as well as gynecological and obstetric practices that do not respect women's autonomy.).

[111] Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United* States, 24 REPRODUCTIVE HEALTH MATTERS 56, 61 (2016).

[112] Dubravka Šimonović (Special Rapporteur on Violence against Women), *Rep. on a Human-Rights Based Approach to Mistreatment and Obstetric Violence During Childbirth*, U.N. Doc. A/74/137 (July 11, 2019) [https://perma.cc/97XD-HS9D].

analysis of why both an interdisciplinary and human rights framework must underpin public policies. Special Procedures on the rights of persons with disabilities, the rights of indigenous peoples, and the human rights of migrants are also providing an intersectional, rights-based policy approach to reproductive health. Although not binding, the U.N. Educational, Scientific and Cultural Organization ("UNESCO") noted that "health does not depend solely on scientific and technological research developments, but also on psychosocial and cultural factors."[113]

Questions on the right to health generally involve resource allocation and the level of government investment required to fulfill rights obligations. However, when it comes to prevention of harm, all states are obliged to meet that minimum threshold.[114] One way to address this is to examine Bolivia's constitutional provision on the right to health.[115]

The Committee on the Elimination of Discrimination Against Women ("CEDAW Committee") has heard several cases concerning obstetric violence in Spain in recent years.[116] In a significant ruling with profound implications for addressing violence against women in the healthcare system, the CEDAW Committee recommended that Spain provide effective reparations and financial compensation to M.D.C.P. for the damages she suffered as a result of obstetric violence.[117] M.D.C.P. visited a public hospital for delivery, but her experience deviated from the standard guidelines for normal delivery care.[118] She was informed that a cesarean section was necessary due to overcrowding in the delivery rooms.[119] Despite refusing the surgery, she was transferred to the operating room, where her daughter was delivered via cesarean section against her wishes.[120] Postoperative pain was

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[113] United Nations Educational, Scientific and Cultural Organization [UNESCO], *Universal Declaration of Bioethics and Human Rights*, U.N. Doc. SHS/EST/BIO/06/1 (Oct. 2005).

[114] OHCHR & WHO, *The Right to Health: Fact Sheet No. 31* (June 2008), https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf.

[115] CONSTITUTION OF BOLIVIA art. 18 (2009) (Bol.) ("There shall be a single health system, which shall be universal, free, equitable, intra-cultural, intercultural, and participatory, with quality, kindness and social control…based on the principles of solidarity, efficiency and co-responsibility….").

[116] *See e.g.*, CEDAW Committee Dec. U.N. Doc. CEDAW/C/75/D/138/2018 (Feb. 28, 2020) (recommending reparations for S.M.F., who experienced unnecessary interventions without her consent at a public Spanish hospital); CEDAW Committee Dec. U.N. Doc. CEDAW/C/82/D/149/2019 (July 13, 2022) (recommending reparations for N.A.E. after a Spanish hospital induced labor without informed consent).

[117] CEDAW Committee Dec. U.N. Doc. CEDAW/C/84/D/154/2020, ¶ 8 (Mar. 9, 2023).

[118] *Id.* at ¶ 2.1-2.2. (describing how M.D.C.P. requests for medication were disregarded and how she was coerced into agreeing to epidural analgesia, which resulted in multiple challenging punctures during the procedure).

[119] *Id.* at ¶ 2.4.

[120] *Id.*

left unaddressed, with no pain medication or attention provided.[121] In the postpartum phase, she sought relief for neck and lower back pain, which professionals attributed to the epidural punctures.[122] Additionally, M.D.C.P. experienced psychological distress, including post-traumatic stress disorder, as a result of mistreatment and neglect during childbirth.[123]

Although she filed a claim against the hospital, citing discrimination, it was dismissed by the court due to the perceived necessity of the cesarean section for the health of both the mother and child.[124] Despite appealing the decision on the grounds of a violated right to effective judicial protection, her appeal was also rejected.[125] Consequently, she lodged a complaint with the Constitutional Court, alleging sex discrimination, challenging not only the findings of the national authorities but also the denial of justice and gender-based discrimination resulting from stereotypes embedded within health and judicial institutions.[126] M.D.C.P. further asserted that states bear the obligation to prevent obstetric violence by eradicating discriminatory customs and ensuring women's full and informed consent.[127] In a third-party intervention, the Study Centre for Human Rights and Humanitarian Law at Pantheon-Assas University defined obstetric violence as a form of gender discrimination occurring within healthcare settings during the process of labor.[128] They advocated for the criminalization of obstetric violence, accompanied by appropriate legal penalties, while emphasizing the need for effective remedies that are free from stereotypes.[129]

In the context of M.D.C.P., the recommendations of the CEDAW Committee reflect a comprehensive understanding of obstetric mistreatment and its ramifications. The Committee scrutinized the failure of laws, policies, and regulations to effectively prevent obstetric violence and provide adequate remedies for the harm caused.[130] Moreover, the Committee identified various factors that contribute to the occurrence of mistreatment during childbirth, including structural elements related to gender and pregnancy norms, as well

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[121] *Id.*
[122] *Id.* at ¶ 2.5.
[123] *Id.* at ¶ 2.6.
[124] *Id.* at ¶ 2.10.
[125] *Id.* at ¶ 2.12.
[126] *Id.* at ¶ 2.13-17. ("The author maintains that obstetric violence is a type of violence that can only be exercised against women and constitutes one of the most serious forms of discrimination.").
[127] *Id.* at ¶ 3.6.
[128] *Id.* at ¶ 6.1.
[129] *Id.* at ¶ 6.2-6.3.
[130] *Id.* at ¶ 7.8-12.

as economic and social norms that shape healthcare delivery.[131] The Committee urged Spain's healthcare systems to undergo a cultural shift in obstetric care and to seek remedies within the human rights framework of the CEDAW, aiming not only to provide full reparation to victims of obstetric violence but also to prevent such forms of violence from occurring in the future.[132]

The inclusion of obstetric violence within the global human rights legal framework necessitates the recognition that the mistreatment of women during childbirth differs from other forms of medical negligence or patient mistreatment. It is not merely a result of medical malpractice but is rooted in structural inequalities and power imbalances between healthcare professionals and pregnant women. This perspective aligns with Paul Farmer's thesis that institutions can perpetuate violence due to social, economic, and other contextual factors.[133]

The concept of structural violence, initially coined by Johan Galtung and further developed by liberation theologians in the 1960s, refers to the social structures—such as economic, political, legal, religious, and cultural systems—that hinder individuals, groups, and societies from realizing their full potential.[134] While the term "violence" often evokes a physical image in common usage, Galtung defines it as the "avoidable hindrance of fundamental human needs" or the reduction of one's capacity to meet those needs below what would otherwise be possible.[135] Structural violence tends to be deeply ingrained in pervasive social structures that are normalized by stable institutions and common experiences, rendering them nearly invisible. Disparities in access to resources, political power, education, healthcare, and legal status are examples of structural violence. This notion of structural violence is closely tied to social injustice and the mechanisms of oppression in society.[136]

The limited circulation of the concept of structural violence or similar notions within the fields of medicine and public health raises questions regarding its absence, particularly considering the potential of such concepts to significantly influence the distribution and outcomes of diseases. Given the capacity of interventions to profoundly impact clinical outcomes, it becomes crucial to explore why structural interventions are not more widely embraced in these fields.

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[131] *Id.* at ¶ 7.10.
[132] *Id.* at ¶ 8.
[133] Farmer, *supra* note 2, at 1686.
[134] *Id.*
[135] Galtung, *supra* note 7, at 173.
[136] BANDY X. LEE, VIOLENCE: AN INTERDISCIPLINARY APPROACH TO CAUSES, CONSEQUENCES, AND CURES 136-137 (1st ed. 2019).

Empowering patients by increasing their agency can effectively reduce the risk of medical abuse.[137] Recognizing that structural interventions may yield greater benefits for disease control compared to conventional clinical interventions, it is imperative to give due consideration to these approaches. One approach to addressing this is through the incorporation of a gendered socio-economic perspective when obtaining patients' consent in childbirth or fertility-related procedures. By adopting such an approach, we acknowledge the interconnectedness of social and economic factors with patients' experiences, highlighting the importance of contextualizing medical decisions within broader social dynamics.

III. INTERNATIONAL FRAMEWORK: LOCATING FORCED STERILIZATION AND OBSTETRIC VIOLENCE WITHIN THE GLOBAL HUMAN RIGHTS LEGAL FRAMEWORK

The treaty body committees of the nine core human rights treaties are empowered to monitor states parties' compliance with their obligations under the specific treaty. On the other hand, special procedures (SPs) are mechanisms of the Human Rights Council (HRC) established to address specific thematic or country situations. The Council derives this authority from the U.N. Charter.[138] SPs are required to submit annual reports to the Council on thematic issues of global importance and engage in standard setting of human rights. In this section, I will examine the evolving work of the treaty bodies and the Special Rapporteurs as a way to develop a framework for digital violence.

Access to reproductive health constitutes a means of accessing human rights, particularly the right to the highest attainable standard of health (which includes reproductive rights), along with other human rights such as the rights to non-discrimination and equality, respect for private life, the right to life, and the right to freedom from torture and cruel, inhuman and degrading treatment. The International Convention on Civil and Political Rights (ICCPR),[139] the CEDAW,[140, 141] and the

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[137] Jie Chen ET AL., *Personalized Strategies to Activate and Empower Patients in Health Care and Reduce Health Disparities*, 43 HEALTH EDUC. BEHAV. 25, 29.

[138] G.A. Res. 60/251, ¶ 1 (Apr. 3, 2006).

[139] G.A. Res. 2200A (XXI), International Covenant on Civil and Political Rights [ICCPR], art. 7, (Dec. 16, 1966). ("[N] o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."); *id.* at art. 10. ("All persons… shall be treated with humanity and with respect for the inherent dignity of the human person.").

[140] CEDAW, *supra* note 5, at art. 2. ("States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women…").

[141] *Id.* at art. 12. ("[i]t is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women.").

International Covenant on Economic, Social and Cultural Rights (ICESCR) assert these rights guarantees.[142] Treaty bodies created and empowered under these treaties examine States' compliance with human rights obligations, as do the HRC and the SPs created by it. These bodies have repeatedly recognized that reproductive rights are necessary to fulfill the rights to equality and non-discrimination, life, privacy, health, and freedom from torture, cruel, inhuman, and degrading treatment, as well as freedom from gender-based violence, among other rights.[143]

In treaty body Concluding Observations and Concluding Comments, the treaty bodies have made reproductive rights central to their recommendations to States.[144] The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment declared that "international human rights law increasingly recognizes that abuse and mistreatment of women seeking reproductive health services cause tremendous and lasting physical and emotional suffering[,]" which can constitute cruel and degrading treatment.[145] The HRC has made it clear that mental suffering violates this

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[142] G.A. Res. 2200A (XXI), International Covenant on Economic, Social and Cultural Rights [ICESPR], art. 3, (Dec. 16, 1966). ("The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.").

[143] *See, e.g.*, HRC, *General Comment No. 36: Article 6 of the ICCPR, On the Right to Life [General Comment No. 36]*, U.N. Doc. CCPR/C/GC/36 (Sept. 3, 2019) (declaring that health measures "must not result in violation of the right to life of a pregnant woman or girl[,]" "jeopardize their lives, subject them to physical or mental pain or suffering[,]" or "discriminate against them or arbitrarily interfere with their privacy") [https://perma.cc/97XD-HS9D]; Committee on Economic, Social and Cultural Rights ("CESCR"), *General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the ICESCR) [General Comment No. 22]*, ¶ 10, U.N. Doc. E/C.12/GC/22 (May 2, 2016) ("The right to sexual and reproductive health is also indivisible from and interdependent with other human rights"); OHCHR, Information Series on Sexual and Reproductive Health Rights: Abortion (2020), https://www.ohchr.org/sites/default /files/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf ("Treaty body jurisprudence has indicated that denying women access to abortion can amount to violations of the rights to health, privacy and, in certain cases, the right to be free from cruel, inhumane and degrading treatment.") [https://perma.cc/JN32-HEE6].

[144] *See* Human Rights Council [HRC], *Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice Today (WGDAW)*, ¶ 35, U.N. Doc. A/HRC/38/46 (May 14, 2018) (averring that "the right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy, involving intimate matters of physical and psychological integrity, and is a precondition for the enjoyment of other rights"); *see also* HRC, *Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice*, U.N. Doc. A/HRC/32/44 (Apr. 8, 2016) ("Women's non-discriminatory enjoyment of the right to health must be autonomous, effective and affordable . . .") [https://perma.cc/ZY3E-THTC].

[145] HRC, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 42, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016) [https://perma.cc/F23G-T7G8].

article and has viewed restrictions on abortion as a violation of the right to be free from torture, cruel, inhuman and degrading treatment since the first case on abortion was decided in the U.N. system. [146]

The CEDAW Committee has identified a direct relationship between abortion access and the prohibition on torture, finding that "violations of women's sexual and reproductive health and rights" such as "criminalization of abortion, denial or delay of safe abortion and post-abortion care, [and] forced continuation of pregnancy. . . are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment."[147] At the 1994 International Conference on Population and Development ("ICPD"), states collectively acknowledged that "reproductive rights embrace certain human rights" and that ensuring access to safe abortion is critical to women's reproductive health.[148] Human rights bodies have also articulated the effects of abortion restrictions and their incompatibility with the rights to equality and non-discrimination, privacy, life, health, and freedom from torture, cruel, inhuman and degrading treatment.[149] Laws restricting abortion access breach the right to equality,

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[146] HRC, *CCPR General Comment No. 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment)* (Mar. 10, 1992); HRC, K.L v. Peru, Communication No. 1153/2003, ¶ 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (Oct. 24, 2005) [https://perma.cc/7W8N-3XUJ].

[147] CEDAW, *General recommendation No. 35 (2017) on gender-based violence against women, updating general recommendation No. 19 (1992),* ¶ 18, U.N. Doc. CEDAW/C/GC/35 (July 26, 2017) [https://perma.cc/L426-BD9L]; CEDAW Committee, *Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the CEDAW*, ¶ 65, U.N. Doc. CEDAW/C/OP.8/GBR/1 (Mar. 6, 2018) (finding that abortion restrictions in Northern Ireland "involve[d] mental or physical suffering constituting violence against women and potentially amounting to torture or cruel, inhuman and degrading treatment") [https://perma.cc/V97M-ZX62]; Fourth World Conference on Women, *Report of the Fourth World Conference on Women*, Beijing 4-15 Sept. 1995, ¶¶ 94-95, U.N. Doc. A/CONF.177/20, annex II (Oct. 17, 1995) (recognizing that "[r]eproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes[,]" including the "right to make decisions concerning reproduction free of discrimination, coercion and violence.") [https://perma.cc/9KVZ-KQRN].

[148] ICPD, Cairo, Egypt, Sept. 5-13, 1994, *Report of the International Conference on Population and Development*, ¶¶ 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [https://perma.cc/DLR5-K6FM].

[149] HRC, *General Comment No. 36*, *supra* note 142, at ¶¶ 8 (declaring that States parties should "remove existing barriers to effective access by women and girls to safe and legal abortion… and should not introduce new barriers.").

discriminating against women and girls on the basis of sex and engaging States' obligations under the ICCPR.[150]

CEDAW requires the safeguarding of women's reproductive rights and health, including abortion access.[151] The CEDAW Committee has also made it clear that "[i]t is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[152] Girls are particularly vulnerable to discrimination because lack of access to reproductive health services "contributes to adolescent girls being the group most at risk of dying or suffering serious or lifelong injuries in pregnancy and childbirth."[153] The Committee on the Rights of the Child (CRC) advised that "[t]here should be no barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization."[154]

Moreover, international human rights treaties require States to take positive measures to achieve substantive equality and address inequalities faced by women and girls that a formal, gender-neutral, or gender-blind approach to equality does not rectify. This includes dismantling the discriminatory, racist, and xenophobic institutional structures and laws surrounding health and abortion services.[155]

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[150] *See* Letter from the WGDAW to the United States, AL USA 11/2020 (May 22, 2020), https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=25279 (last visited June 10, 2023) ("[T]he failure to provide adequate access" to abortion services "constitute[s] discrimination on the basis of sex, in contravention of ICCPR article 2.") [https://perma.cc/HRW8-CU8D].

[151] The CEDAW requires State bodies to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning." CEDAW, *supra* note 5, at art. 12.

[152] CEDAW Committee, *General Recommendation No. 24*, *supra* note 3, at ¶ 11.

[153] Committee on the Rights of the Child [CRC], *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence*, ¶ 59, U.N. Doc. CRC/C/GC/20* (Dec. 6, 2016).

[154] *Id.* at ¶ 60.

[155] *See, e.g.*, CEDAW Committee, *General Recommendation No. 25, on Article 4, paragraph 1, of the CEDAW, on temporary special measures*, (30th Sess., 2004), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, ¶ 12, U.N. Doc. HRI/GEN/1/Rev.7 (May 12, 2004) ("Certain groups of women, in addition to suffering from discrimination directed against them as women, may also suffer from multiple forms of discrimination based on additional grounds such as race, ethnic or religious identity, disability, age, class, caste or other factors. . . . States parties may need to take specific temporary special measures to eliminate such multiple forms of discrimination against women and its compounded negative impact on them.") [https://perma.cc/T4LN-7TKP]; CESCR, *General Comment No. 20: Nondiscrimination in economic, social and cultural rights (art. 2, para. 2, of the ICESCR)*, ¶ 17, U.N. Doc. E/C.12/ GC/20 (July 2, 2009) ("Some individuals or groups of individuals face discrimination on more than one of the

States must recognize that, pursued alone, formal equality disadvantages individuals who face intersectional discrimination on multiple grounds: "groups such as, but not limited to, poor women, persons with disabilities, migrants, indigenous or other ethnic minorities, adolescents, lesbian, gay, bisexual, transgender and intersex persons, and people living with HIV/AIDS are more likely to experience multiple discrimination" and "may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health."[156]

Forced sterilization and other forms of obstetrics violence result in intersectional discrimination compounded by poverty, impacting low-income women who would like to exercise their constitutional, privacy-derived right. The CESCR clarified that States are required "to eradicate practical barriers" including "disproportionate costs and lack of physical or geographical access to sexual and reproductive health care."[157] Special Rapporteur Mofokeng noted recently that "[w]omen, adolescents, girls and all persons capable of becoming pregnant have a right to make informed, free and responsible decisions concerning their reproduction, their body and sexual and reproductive health, free of discrimination, coercion and violence."[158]

On the issue of informed consent, the CEDAW Committee has recommended that States "require all health services to be consistent with the

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prohibited grounds, for example women belonging to an ethnic or religious minority. Such cumulative discrimination has a unique and specific impact on individuals and merits particular consideration and remedying."); HRC, *CCPR General Comment No. 28: Article 3 (The equality of rights between men and women)*, ¶ 30, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000) ("Discrimination against women is often intertwined with discrimination on other grounds such as race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status. States parties should address the ways in which any instances of discrimination on other grounds affect women in a particular way, and include information on the measures taken to counter these effects.").

[156] CESCR, *General Comment No. 22*, *supra* note 143, at ¶ 30. *See e.g.,* CRPD Committee, *General comment No. 3 (2016) on women and girls with disabilities*, ¶ 2, U.N. Doc. CRPD/C/GC/3 (Nov. 25, 2016) (noting barriers which "create situations of multiple and intersecting forms of discrimination against women and girls with disabilities"); HRC, Mellet v. Ireland, *Views adopted by the Committee under article 5 (4) of the Optional Protocol, concerning communication No. 2324/2013*, ¶ 7.11, U.N. Doc. CCPR/C/116/D/2324/2013 (Nov. 17, 2016) (finding differential treatment where Ireland "failed to adequately take into account [woman's] medical needs and socioeconomic circumstances"); HRC, Whelan v. Ireland, *Views adopted by the Committee under article 5 (4) of the Optional Protocol, concerning communication No. 2425/2014*, ¶ 7.12, U.N. Doc. CCPR/C/119/D/2425/2014 (July 11, 2017) (finding the same).

[157] CESCR, *General Comment No. 22*, *supra* note 144, at ¶ 46.

[158] Tlaleng Mofokeng (Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health), *Rep. on Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic*, ¶ 40-41, U.N. Doc. A/76/172 (July 16, 2021) [https://perma.cc/EPC3-2E66].

human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[159] The HRC has found violations of the right to privacy in every case before it when the State interferes with reproductive decision-making.[160]

The Report of the Special Rapporteur on Health to the Human Rights Council has recognized that ensuring universal access to sexual and reproductive healthcare services must be fulfilled, in part, by States adopting "a comprehensive gender-sensitive and non-discriminatory sexual and reproductive health policy" consistent with human rights standards.[161] The CESCR notes that "[h]ealth facilities, goods, information and services related to sexual and reproductive health care should be accessible to all individuals and groups without discrimination and free from barriers."[162] The requirement of accessibility is made up of four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility.[163] Accordingly, the CESCR recommends that to enable the realization of a woman's right to health, States Parties should remove "all barriers interfering with [a woman's] access to health services, education and information including in the area of sexual and reproductive health."[164]

During the Covid-19 pandemic, at a time when reproductive health services were largely suspended in many parts of the world, nascent results in Pakistan revealed that a telehealth accompaniment model was able to overcome the digital divide in the provision of sexual and reproductive health services for women accessing care.[165] Inequitable access to digital sexual and reproductive health services, especially in the frontier provinces in many

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[159] CEDAW Committee, *General Comment No. 24*, *supra* note 3, at ¶ 31(e). *See also* CEDAW 2018 UK Report, ¶ 65 (noting that the restrictive abortion law in Northern Ireland "affronts women's freedom of choice and autonomy and their right to self-determination"); ICCPR, *supra* note 139, at art. 17 (proclaiming that the right to privacy encompasses women's reproductive autonomy).

[160] *See* HRC, *General Comment No. 36*, *supra* note 142, ¶ 8 (referencing right to privacy).

[161] HRC, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, ¶ 89-92, U.N. Doc. A/HRC/32/32 (Apr. 4, 2016).

[162] CESCR, *Comment No. 22*, *supra* note 142, at ¶ 15.

[163] CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, ¶ 12(b), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

[164] *Id.* at ¶ 21.

[165] Irum Shaikh et al., *Telehealth for Addressing Sexual and Reproductive Health and Rights Needs During the COVID-19 Pandemic and Beyond: A Hybrid Telemedicine-Community Accompaniment Model for Abortion and Contraception Services in Pakistan*, FRONTIERS IN GLOB. WOMEN'S HEALTH (July 26, 2021), https://www.frontiersin.org/articles/10.3389/fgwh.2021.705262/full [https://perma.cc/7NWH-MP72].

countries, is the next frontier in structural challenges to women's human rights in obstetric care.[166]

Despite telemedicine's potential to democratize access to healthcare, telemedicine is not always developed from a gender equity perspective. The power structures need to change in the development and deployment of telemedicine for women, especially in obstetrics and gynecology that help advance women's autonomy and decision-making. Writing on the asymmetry of power that leads to structural violence in healthcare, Paul Farmer argues that structures are neither natural nor neutral but are instead embedded in histories of political, economic, and social power.[167] "Structural violence" thus provides us with a lens to identify differences within social structures that are inequitable and the connection between those structures of power and the harm caused to underrepresented minorities. Obstetric care is a site of gendered power differences that often results in both anticipated and unanticipated violence.

Both the ICCPR and the CEDAW illustrate the intersectional scope of the treaties and the structural causes of violence and abuse. As seen below, the categories of intersectional differences set out in both treaties examine the historical power differences that lie at the roots of such conduct in the first place. Secondly, the treaties help establish the legal framework for the power and control aspect of obstetric violence.

ICCPR Article 2, Section 1 states: "Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."[168]

CEDAW Article 1 states that "discrimination against women" means "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."[169]

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[166] An exploratory study of how telemedicine altered healthcare in Nepal revealed that rural telemedicine services had removed some barriers to women in encouraging them to ask about sexual health priorities. Kendall Morgan, *Telemedicine Helps to Overcome Gender-Based Barriers to Healthcare*, ELSEVIER (Apr. 18, 2018), https://www.elsevier.com/connect/atlas/telemedicine-helps-to-overcome-gender-based-barriers-to-healthcare [https://perma.cc/EPC3-2E66].

[167] PAUL FARMER, PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS, AND THE NEW WAR ON THE POOR 402 (2004).

[168] ICCPR, *supra* note 138, at art. 7.

[169] CEDAW, *supra* note 5, at art. 1.

At their core, the treaties help reveal how the argument that women are free to exercise the option to leave an abusive gynecological environment masks the power differences at play, especially between professional care providers and those seeking care before, during, and after pregnancy. Although an isolated act of abuse may not rise to the level where it meets a legal threshold, we need to view obstetrics violence as a continuum of gender and intersectional violence. The names used to describe a phenomenon have the power to shift social norms, much like the way advocates succeeded in naming domestic violence in the 1970s and sexual harassment in the 1990s as legally actionable categories of violence.

CONCLUSION: A GROWING CHALLENGE FOR THE CEDAW COMMITTEE

In the final analysis, I come back to *Buck v. Bell*. My esteemed colleague at the University of Pennsylvania Law School, Jasmine Harris, powerfully argues:

> . . . to many, *Buck* reads as a relic from another time or a distant cautionary tale about the exercise of state violence over disfavored bodies. . . . To women, people of color, those with disabilities, and those with multiple marginalized identities, however, *Buck v. Bell* is perennial, its principles supporting institutional racism and ableism, among other forms of systemic discrimination.[170]

Another distinguished colleague, the critical race scholar Dorothy Roberts, has produced groundbreaking work on *Killing the Black Body*, illustrating how the bodies of Black, Brown, Indigenous, and disabled women are often battlegrounds where battles based on race, class, migrant status, and indigent status are waged.

As a normative framework, the CEDAW offers substantive and procedural safeguards to address claims related to reproductive health and population. Article 12 of the CEDAW guarantees formal equality, ensuring that men and women are afforded the same rights and conditions in healthcare,[171] as well as substantive equality.[172] These provisions require

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[170] Jasmine E. Harris, *Why* Buck v. Bell *Still Matters*, HARV. L. PETRIE-FLOM CTR. (Oct. 14, 2020), https://blog.petrieflom.law.harvard.edu/2020/10/14/why-buck-v-bell-still-matters/ [https://perma.cc/BK4R-ZZZ3].

[171] CEDAW, *supra* note 5, at art. 12(1). ("States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.").

[172] *Id.* at art. 12(2). (". . . .States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.").

affirmative programs exclusively for women. The provision ought to be construed in its broader context, emphasizing the promotion of safe and healthy deliveries. Another issue that must be tackled at the national and local levels is the care for women of diverse socioeconomic status, especially minority women, and the care they must receive. Barriers to access to care include obtaining consent for seeking care and accessing female healthcare workers. The interpretation of the CEDAW is critical to addressing emerging issues resulting from technological advancements, such as telemedicine, in both urban and rural populations around the world.

Healthcare is increasingly being delivered through digital channels, such as the internet, mobile phone messaging, social media, apps, voice and video messaging, and telemedicine. This trend has been facilitated by emerging mobile technology and advancements in artificial intelligence. Digital channels provide broad access to particular groups or individuals and may augment the delivery of information and support related to sexual and reproductive health and rights.

Questions remain regarding digital interventions across different cultural contexts and socioeconomic groups, especially those at high risk. Given the highly sensitive nature of this information, women in many settings are often victims of both personal and institutional reproductive coercion. Although there are a number of uses for telemedicine in obstetrics, implementation of such technologies must be sensitive to the potential risks of using digital technology to convey information and facilitate care. It is important to anticipate potential gender-based negative impacts in the design, evaluation, or implementation of reproductive healthcare interventions. This is an evolving challenge for the international human rights community.

In closing, I pursue two arguments that address new policymaking and legislative drafting. The case of *María Mamérita Mestanza Chávez v. Peru* before the Inter-American Commission on Human Rights stands as a seminal example where Peru admitted responsibility for the forced sterilization and death of Mestanza Chavez due to inadequate medical care.[173] Peru not only agreed to compensating the family members but also to revising laws and policies to prevent discrimination in reproductive policies, particularly concerning marginalized and indigenous communities.[174]

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[173] *María Mamerita Mestanza Chávez v. Peru (Inter-American Commission on Human Rights)*, CTR. FOR REPROD. RTS. (last updated Mar. 18, 2021), https://reproductiverights.org/case/maria-mamerita-mestanza-chavez-v-peru-inter-american-commission-on-human-rights/ [https://perma.cc/K5MA-U8ET].

[174] María Mamérita Mestanza Chávez v. Peru, Petition 12.191, Inter-Am. Comm'n H.R., Report No. 71/03, ¶ 14 (Oct. 22, 2003) [https://perma.cc/Q4N5-SZN7].

Framing forced sterilization as institutionalized violence in gender-based violence legislation can help in addressing it in domestic courts.

Lastly, as state sponsored campaigns on forced and coerced sterilization continue to be carried out against Afro-descendant, indigenous, and intellectually disabled women,[175] it is important that new policies and laws adopt an intersectional lens in addressing forced sterilization. A recent report on the forced sterilization of women with disabilities shows that Belgium, France, and Luxembourg have explicitly criminalized forced sterilization as a war crime.[176] This is also in keeping with Article 7 of the Rome Statute on the International Criminal Court, which includes forced sterilization as a crime against humanity and provides new directions for law and policy.[177]

[175] Priti Patel, *Forced Sterilization of Women as Discrimination*, 38 PUB. HEALTH R., at 2, 1.
[176] Marine Uldry & Eur. Disability F, Women's Comm., *Forced Sterilisation of Persons with Disabilities in the European Union*, EUR. DISABILITY F. 21 (Sept. 2022), https://www.edf-feph.org/content/uploads/2022/09/Final-Forced-Sterilisarion-Report-2022-European-Union-copia_compressed.pdf [https://perma.cc/4XST-ZZ5Z].
[177] Rome Statute of the Int'l Crim. Ct., art. 7 (July 17, 1998), 2187 U.N.T.S. 90.