

Original author version 29 January 2024

Final version published online in Oxford Public International Law, Oxford Report on International Law (Oxford University Press) | 10 March 2025:

<https://opil.ouplaw.com/display/10.1093/law-ihrl/4452cedaw23.case.1/law-ihrl-4452cedaw23?print>

MDCP v Spain, Admissibility and merits, UN Doc CEDAW/C/84/D/154/2020, IHRL 4452 (CEDAW 2023), 24th February 2023, United Nations [UN]; Committee on the Elimination of Discrimination against Women [CEDAW]

by Aleydis Nissen and Valentina Vivallo Toro*

Obstetric violence

Date:	24 February 2023
Citation(s):	UN Doc CEDAW/C/84/D/154/2020 (Official Case No)
Jurisdiction:	United Nations; Committee on the Elimination of Discrimination against Women
Parties:	MDCP (represented by counsel, Francisca Fernández Guillén and Marina Morla González) Spain
Third Party:	Study Centre for Human Rights and Humanitarian Law of the Panthéon-Assas University (Paris)
Procedural Stage:	Admissibility and merits

* Aleydis is a human rights lawyer and researcher specialising in gender barriers to justice. She currently works at the Fonds de la Recherche Scientifique, Université Libre de Bruxelles, and the University of Antwerp. Previously, she worked at Leiden University, where she coordinated the course 'Women's Rights' in the Advanced Master's Degree in European and International Human Rights Law.

Valentina is a human rights lawyer and researcher specialising in international human rights law and digital technologies. She currently serves as a consultant with UNHCR, where she coordinates the Cartagena+40 Process in cooperation with the Ministry of Foreign Affairs of Chile, and undertakes complementary research on artificial intelligence and digital technologies. This article builds on collaborations developed following her Advanced Master's Degree in European and International Human Rights Law at Leiden University.

ABSTRACT

In *MDCP v Spain*, the United Nations Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) advanced its understanding of obstetric violence as structural and systemic gender-based violence. It recognised that such violence is rooted in patriarchal norms, hierarchical medical culture, and inadequate training on women's rights — factors that are intensified by challenging or poor working conditions for healthcare professionals, which can lead to the dehumanisation of patients. On the merits, the Committee found Spain violated MDCP's rights through lack of informed consent for a caesarean, inadequate examinations, and disrespectful treatment — contrary to the requirement for evidence-based, stereotype-free care. Compared to earlier cases against Spain (*SFM* and *NAE*), the Committee issued broader recommendations: revising gender-based violence laws to include obstetric violence, extending patients' rights to reproductive health, and launching public awareness campaigns. Overall, the decision confirms CEDAW's evolving role as a normative authority addressing systemic discrimination, and aligns with the longstanding demands of Spain's women's rights movement to recognise obstetric violence as a human rights violation.

CORE ISSUE

Whether a state's failure to protect the author from discrimination and violence during, before and after childbirth, and to provide remediation violates *Articles 2, read in conjunction with articles 1, 3, 4, 5 and 24, and under articles 3, 5 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women*.

FACTS

F1 MDCP entered into labour without complexities. According to the initial examination in a public hospital in Sevilla, the baby's health was satisfactory. However, MDCP's amniotic sac was artificially ruptured, and synthetic oxytocin was administered to her without recorded clinical reasons.

F2 MDCP requested water and medication for her pre-existing hiatal hernia, but her requests were allegedly ignored. Instead, she allegedly experienced forced dilation in a lithotomy position, causing her pain.

F3 Three staff members, including two student trainees, administered epidural analgesia. The medical records indicate that the students attempted epidural punctures several times, causing bleeding.

F4 MDCP was allegedly informed she would be taken to a delivery room, but she overheard that the delivery rooms were overcrowded. Despite her refusal of surgery, her baby was delivered by a caesarean section in the surgical ward, causing her pain. Her medical records do not indicate that pain medication was given. During the post-partum period, MDCP also experienced physical and psychological suffering, including post-partum post-traumatic stress disorder.

F5 MDCP submitted an administrative claim to the Andalusian Health Service seeking financial responsibility from the public hospital for malpractice during childbirth, primarily in the administration and irregular practice of epidural analgesia, the lack of informed consent to perform and the inappropriate execution of the caesarean section.

F6 As the administration did not respond, MDCP filed an application with the Administrative Court of Seville against the presumed dismissal of her claim, invoking financial responsibility. She claimed a lack of informed consent and violations of her dignity and her right to physical and mental integrity. The hospital administration stated that a caesarean section was necessary because the dilation had stopped progressing but did not provide evidence to support this claim or to justify the urgency based on a risk to the health of the mother or the foetus.

F7 The Court dismissed the author's application due to a lack of evidence provided by her to support her claims. The lack of a signed informed consent form (required by Spanish law) was deemed irrelevant due to the urgent nature of the caesarean section.

F8 MDCP submitted an appeal before the High Court of Justice of Andalusia, claiming a violation of the right to effective judicial protection. She argued that the judge did not assess the evidence, and the defendants did not prove informed consent. The author claimed that justice was denied based on gender stereotypes.

F9 The appeal was rejected. The Court held that the informed consent was adequately obtained by informing MDCP's husband and mother based on the urgent need for a caesarean section. Additionally, it stated that MDCP did not provide evidence of overcrowding in the delivery rooms.

F10 MDCP filed an *amparo* application with the Constitutional Court claiming a violation of her right to equity before the law without discrimination based on sex. She argued that her capability to make decisions and be informed about her and her baby daughter's health was disregarded because she was a pregnant woman.

F11 The *amparo* was dismissed because the facts were not of particular constitutional significance.

F12 During and after her labour, MDCP claimed that her rights under *Articles 3*, *5*, and *12 of the Convention on the Elimination of All Forms of Discrimination against Women (18 December 1979) 1249 UNTS 13, entered into force 3 September 1981* (CEDAW) were violated due to inadequate medical care. This situation resulted in a violation of her physical and psychological integrity, as well as her personal and family privacy. Additionally, her rights to receive information and decide freely were violated. Furthermore, she experienced gender discrimination during childbirth because only pregnant women can consent to interventions. These facts violate *Article 2* in conjunction with *Articles 1*, *3*, *4*, *5* and *24 of the CEDAW*.

F13 MDCP requested reparations for violations, non-repetition measures, and a general recommendation on obstetric violence from the Committee that monitors CEDAW.

F14 Spain argued that the communication was inadmissible because it had been declared inadmissible by the European Court of Human Rights, it pretended to review the evidence assessment conducted by the domestic courts, and the domestic remedies were not exhausted. Spain furthermore argued that the assessment of the evidence was not arbitrary, no manifest error was made, and justice was not denied. The state also claimed that there were no allegations of violations of fundamental rights during the domestic proceedings. Instead, it argued that the case involved a claim invoking financial responsibility, followed by an administrative application and an application for *amparo*.

HELD

H1 The Committee held that the same matter had not been examined by the European Court of Human Rights since the declaration of inadmissibility did not consider the case's merits. There was no reason for it to be deemed inadmissible under *Article 4 (2) (a) of the Optional Protocol to the

Convention on the Elimination of All Forms of Discrimination against Women (15 October 1999) A/RES/54/4, entered into force 22 December 2000* ('Optional Protocol'). **[para 7.2]**

H2 Furthermore, MDCP exhausted domestic remedies, and she is not seeking a simple review of these remedies' assessment of facts and evidence. **[paras 7.3 and 7.4]** Rather, the Committee must consider whether a denial of justice and gender-based discrimination resulting from stereotypes has occurred. **[para 7.4]**

H3 Quality healthcare services should ensure fully informed consent, respect for dignity, confidentiality, and sensitivity to women's needs and perspectives as per General Recommendation No. 24 (1999) on women and health (Article 12), UN Doc A/54/38/Rev.1, chap. I, CEDAW, 1999. **[para 7.7]**

H4 The CEDAW stressed that states must adopt laws and policies to protect pregnant women during childbirth and sanction obstetric violence. Medical professionals should receive capacity-building training, and healthcare centres and hospitals must undergo regular monitoring of patient treatment. **[para 7.9]**

H5 Spain did not comply with its due diligence obligation in the administrative and judicial proceedings. The national authorities did not conduct an exhaustive analysis of the evidence for the present case, which makes clear that the applicable standards and protocols had not been followed during childbirth. The judge overlooked the disregard for appropriate protocols, the absence of informed consent forms (required by Spanish law) or reports provided by the author as evidence of malpractice, specifically an expert report from a specialist in gynaecology and obstetrics. The judge also failed to consider information submitted regarding post-partum post-traumatic stress disorder. Regarding the latter, the humiliation the author experienced arose from not being treated as a subject capable of looking after her health and that of her daughter. **[para 7.10, 7.11]**

H6 In light of the facts of the case – in particular, the loss of dignity, the failure to consider pre-existing conditions, the abuse and mistreatment suffered, the irregular application of epidural analgesia without informed consent and/or without having justified the need for such interventions, and the failure to obtain informed consent prior to performing a caesarean section – the author experienced obstetric violence, resulting in physical and psychological harm. **[para 7.12]**

H7 According to *Articles 2 (f)* and *5 of the CEDAW*, states have a positive obligation to take all appropriate measures to modify or abolish laws, regulations, customs and practices that constitute discrimination against women. Given that gender stereotyping is a practice that undermines women's right to be protected against obstetric violence, the state authorities who investigate those acts must also avoid its perpetuation. In that vein, the administrative and judicial authorities of the state applied

stereotypical and discriminatory notions of gender by disregarding the author's right to be informed and to decide freely whether to undergo a caesarean section. [para 7.13]

H8 The state violated Article 2, read in conjunction with Articles 1, 3, 5 and 24, and Articles 3, 5 and 12 of the CEDAW. [para 7.14]

H9 The state had to provide the author with full reparation, including adequate financial compensation due to the physical and psychological damage caused. [para 8]

H10 In general, the state has to ensure adequate access to healthcare services for women during pregnancy, childbirth and postpartum. It likewise has to uphold women's rights to safe motherhood and access to appropriate obstetric services, provide adequate information at each stage of childbirth, establish a requirement for their free, prior and informed consent, and respect their autonomy and decision-making capacity. The state also has to ensure that the staff working in health services comply with the abovementioned obligations. Thereto, adequate professional training is needed to enable staff to recognise gender-based violence against women. Judicial and law enforcement personnel should get similar specialised training, as there need to be effective remedies in cases in which women's rights have been violated. Awareness campaigns, research-based guidance for public policies, a 'patient's bill of rights' and public dialogue in the media and beyond need to be developed. The state has to review its existing legislation to recognise obstetric violence as gender-based violence against women. [para 8]

ANALYSIS

A1 The Committee followed the concept of obstetric violence as proposed by the Special Rapporteur on Violence against Women, which focuses on the violence against women experienced during facility-based childbirth ([*Report of the Special Rapporteur on violence against women, its causes and consequences, on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth care and obstetric violence](#) (2019), UN Doc A/74/137, 11 July 2019*, para 12). It is worth noting that the Inter-American Court of Human Rights used the concept of obstetric violence to refer to human rights violations and gender-based violence during pregnancy, childbirth, and postpartum in access to health services ([*Brítez Arce et al. v Argentina](#), Inter-American Court of Human Rights, Merits, Reparations and Costs. 16 November 2022*, para 75 {mentioned only in headnote}). The latter definition thus finds that more acts can be recognised as constituting obstetric violence. In the auspices of the Council of Europe, such broader conceptualisation has been labelled as 'obstetrical and gynaecological violence'. ([*Report of the Special Rapporteur on violence against women, its causes and consequences, on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth care and obstetric violence](#) (2019), UN Doc A/74/137, 11 July 2019*, para 7).

A2 This communication is in line with other decisions of the CEDAW concerning obstetric violence on similar facts of this case, within the same context and state party (**NAE v Spain*, UN Doc CEDAW/C/82/D/149/2019, 13 July 2022*, and *SFM v Spain*, UN Doc CEDAW/C/75/D/138/2018, 28 February 2020*). Yet, the communication goes further in various regards by further addressing the structural and systemic nature of obstetric violence (see **Fleur Van Leeuwen and Gulay Malkoc, Obstetric Violence as a Violation of Human Rights: CEDAW's Second Decision a Welcome Addition but Not Enough*, (2022), Oxford Human Rights Hub*, {mentioned only in headnote}). Strangely, Spain tried to argue that the structural nature of such violence made individual reparation unnecessary. **[para 4.7]**

A3 The structural and systemic discrimination against women in healthcare systems during facility-based childbirth was also recognised by the World Health Organization **[para 2.19]** and the Special Rapporteur on violence against women (**Report of the Special Rapporteur on violence against women, its causes and consequences, on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth care and obstetric violence* (2019), UN Doc A/74/137, 11 July 2019*, para 4).

A4 The women's rights movement made the structural nature of obstetric violence visible. Three important factors can be described here. Firstly, a patriarchal society and gender bias lead to disregard for women's right to make decisions, which is frequently naturalised among health workers and patients, including in the historically male-dominated obstetrical and gynaecological field. Secondly, a hierarchical treatment from the medical team towards the patient and a hierarchical dependence on the patient's social status that emphasises inequalities and discrimination play a key role in obstetric violence. Thirdly, there is a shortage of training and skills in women's rights and all emotional and physical aspects of pregnancy, childbirth and puerperium through health workers. Fear of retaliation often prevents professionals from denouncing wrongdoing. (See **Desirée Mena-Tudela et al., From Experiences with obstetric violence among healthcare professionals and students in Spain: a constructivist grounded theory study*, (2023), Elsevier *Women and Birth**, p219-226 {mentioned only in headnote}, and **Rodríguez Mir and Alejandra Martínez Gandolfi, Obstetric violence. A hidden practice in medical care in Spain*, (2021), *Gac Sanit**, p211-212 {mentioned only in headnote}).

A5 The challenging or poor working conditions for healthcare professionals exacerbate all these issues, and may lead to the dehumanisation of patients. (**Report of the Special Rapporteur on violence against women, its causes and consequences, on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth care and obstetric violence* (2019), UN Doc A/74/137, 11 July 2019*, para 39). One of the staff members referred to such issues by referring to 'the workload in the service' before the epidural analgesia was administered to MDCP. **[para 2.3]** The state perpetuated obstetric violence by not

providing a sufficient regulatory framework to ensure that medical personnel performed their duties without gender bias. While health professionals have the responsibility to uphold the right to health, the state should provide an environment that facilitates the fulfilment of these responsibilities (*Aleydis Nissen, A right to access to emergency health care: the European Court of Human Rights pushes the envelop, (2017), Medical Law Review*, p697-698 {mentioned only in headnote}).

A6 In light of the state's obligations to take positive measures to prevent obstetric violence, the Committee has taken steps to address the situation in Spain by increasing the number of recommendations. Compared to SFM v Spain, seven general recommendations have been added; compared to NAE v Spain, six general recommendations have been added. Thus, the Committee stated that the state must ensure that the personnel working in healthcare establishments adhere to the duties mentioned in the recommendations. It also expanded the scope of the 'patients' bill of rights' to expressly include reproductive health. Further, the Committee advised the creation of public awareness campaigns and stated that discussions involving media should be facilitated to promote awareness of women's rights, particularly in cases of obstetric violence. Lastly, it pointed out that the laws on gender-based violence need to be revised so as to include obstetric violence as a form of it.

A7 The Committee also addressed the specific issues raised in this case: written informed consent to a caesarean section, defective physical examinations and procedures and disrespectful treatment. The communication is in line with the case law of the Inter-American Court, which finds that states should inform pregnant women about their reproductive and maternal health during pregnancy, childbirth and postpartum, based on scientific evidence without bias, free of stereotypes and discrimination, including a birth plan agreed in advance. The lack of adequate medical care may violate women's physical, psychological and moral integrity. (*Brítez Arce et. al v Argentina, Inter-American Court of Human Rights, Merits, Reparations and Costs. 16 November 2022*, para 73-74 {mentioned only in headnote}). Also see *Advisory Opinion 29/22, Inter-American Court of Human Rights, 30 May 2022*, para 158 {mentioned only in headnote}).

A8 In sum, it can be considered that the Committee – as a 'normative power of last resort' (see *Wolf Heydebrand, 'From Globalisation of Law to Law under Globalisation' (2001), David Nelken & Johannes Feest (eds) *Adapting Legal Cultures**, p121 {mentioned only in headnote}) – is increasingly giving substance to the Spanish women's rights movement which has long documented the structural nature of obstetric violence in Spanish hospitals (see *NAE v Spain, UN Doc CEDAW/C/82/D/149/2019, 13 July 2022*, and SFM v Spain, UN Doc CEDAW/C/75/D/138/2018, 28 February 2020*).

CITATIONS

- *Convention on the Elimination of All Forms of Discrimination against Women (18 December 1979) 1249 UNTS 13, entered into force 3 September 1981*, *Articles 1*, *2*, *3*, *4*, *5*, *12* and *24*
- *General Recommendation No. 24 (1999) on women and health (Article 12), UN Doc A/54/38/Rev.1, chap. I, CEDAW, 1999*
- *Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (15 October 1999), UN Doc A/RES/54/4, entered into force 22 December 2000*, *Article 4(1)*, 4(2)(a)*
- *Concluding observations on the combined seventh and eighth periodic reports of Spain (2015), UN Doc CEDAW/C/ESP/CO/7-8, 29 July 2015*
- *Concluding Observations on the seventh periodic report of Costa Rica (2017), UN Doc CEDAW/C/CRI/CO/7, 24 July 2017*
- *Special Rapporteur on violence against women, its causes and consequences, on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth care and obstetric violence (2019), UN Doc A/74/137, 11 July 2019*
-
- *Kayhan v Turkey, UN Doc CEDAW/C/34/D/8/2005, 27 January 2006*
- *TN v Denmark, UN Doc CEDAW/C/59/D/37/2012, 19 December 2014*
- *González Carreño v Spain, UN Doc CEDAW/C/58/D/47/2012, 15 August 2014*
- *HD v Denmark, UN Doc CEDAW/C/70/D/76/2014, 15 August 2018*
- *SFM v Spain, UN Doc CEDAW/C/75/D/138/2018, 28 February 2020*
- *NAE v Spain, UN Doc CEDAW/C/82/D/149/2019, 13 July 2022*
-
- *Trébutien v France, UN Doc CCPR/C/51/D/421/1990, 27 July 1994*
- *Petersen v Germany, UN Doc CCPR/C/80/D/1115/2002, 30 April 2004*
- *Bertelli Gálvez v Spain, UN Doc CCPR/C/84/D/1389/2005, 16 August 2005*
- *Wdowiak v Poland, UN Doc CCPR/C/88/D/1446/2006, 23 November 2006*
- *Alzery v Sweden, UN Doc CCPR/C/88/D/1416/2005, 10 November 2006*
- *Vojnović v Croatia, UN Doc CCPR/C/95/D/1510/2006, 28 April 2009*
- *Onoufriou v Cyprus, UN Doc CCPR/C/100/D/1636/2007, 1 November 2010*
- *Achabal Puertas v Spain, UN Doc CCPR/C/107/D/1945/2010, 18 June 2013*
- *Quliyev v Azerbaijan, UN Doc CCPR/C/112/D/1972/2010, 19 November 2014*
- *X v Norway, UN Doc CCPR/C/115/D/2474/2014, 11 December 2015*
-
- *Advisory Opinion, Differential approaches to certain groups of persons deprived of liberty, OC-29/22, 30 May 2022*



Convention on the Elimination of All Forms of Discrimination against Women

Distr.: General
9 March 2023
English
Original: Spanish

Committee on the Elimination of Discrimination against Women

Views adopted by the Committee under article 7 (3) of the Optional Protocol, concerning communication No. 154/2020^{*,**}

<i>Communication submitted by:</i>	M.D.C.P. (represented by counsel, Francisca Fernández Guillén and Marina Morla González)
<i>Alleged victim:</i>	The author
<i>State party:</i>	Spain
<i>Date of communication:</i>	10 November 2018
<i>References:</i>	Decision taken pursuant to rule 69 of the Committee's rules of procedure, transmitted to the State party on 21 January 2020 (not issued in document form)
<i>Date of adoption of views:</i>	24 February 2023

* Adopted by the Committee at its eighty-fourth session (6–24 February 2023).

** The following members of the Committee participated in the examination of the present communication: Brenda Akia, Hiroko Akizuki, Nicole Ameline, Marion Bethel, Leticia Bonifaz Alfonzo, Rangita De Silva de Alwis, Corinne Dettmeijer-Vermeulen, Esther Eghobamien-Mshelia, Hilary Gbedemah, Yamila González Ferrer, Daphna Hacker, Nahla Haidar, Dalia Leinarte, Rosario G. Manalo, Marianne Mikko, Maya Morsy, Bandana Rana, Rhoda Reddock, Elgun Safarov, Natasha Stott Despoja and Genoveva Tisheva.



1.1 The author of the communication is M.D.C.P., a Spanish national born on 28 September 1971. The author maintains that Spain violated her rights under article 2, read in conjunction with articles 1, 3, 4, 5 and 24, and under articles 3, 5 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women owing to the obstetric violence she experienced in hospital during childbirth. The Convention and the Optional Protocol thereto entered into force in the State party on 4 February 1984 and 6 October 2001, respectively. The author is represented by counsel.

1.2 On 2 June 2020, the Committee received a submission from a third party,¹ which was transmitted to both parties for their comments.

Facts as submitted by the author

2.1 On 6 January 2009, at approximately 7 a.m., after a normal and uncomplicated 40-week pregnancy, the author went to a public hospital in Seville to give birth to her first child, as she was experiencing contractions. Her only pre-existing medical condition was a hiatal hernia, for which she had been treated during her pregnancy. The initial examination showed that her “cervix was 40 per cent effaced and 1–2 cm dilated”² and the baby’s condition was satisfactory. At 12.30 p.m., the normal course of labour was interrupted when the amniotic sac was artificially ruptured and synthetic oxytocin was prescribed. The medical records did not note the clinical reason for rupturing the amniotic sac and administering synthetic oxytocin. Based on the medical records and the expert report by the obstetrics and gynaecology specialist submitted by the author, she did not reach the active phase of labour (4 cm dilated) until after 5.15 p.m. and following a cascade of interventions, which are not advised in the clinical practice guidelines for normal delivery care of the Ministry of Health and Social Policy because they may disrupt the normal progression of labour.

2.2. The author suffered from a hiatal hernia, yet her requests for medication were reportedly ignored and she was forced, against her will, to dilate in the lithotomy position, which caused reflux to coat her throat, putting her in pain. The author reports that the midwife said to her: “Clean yourself up and lie flat on the bed; stay still and keep your legs apart and your knees bent!”. The strategy for normal delivery care of the National Health System provides that women should be encouraged to make informed decisions about the position they consider most comfortable and to freely decide what position to take. The author also notes that she asked for water several times but was not given any and no explanation for this was provided.

2.3 The author reports that, at 3.30 p.m., at only 3 cm dilated and having made no request for it, she was told: “If you don’t agree to the administration of epidural analgesia now, it will be too late by the time you want it or it won’t be possible because of the workload in the service”. The author reports feeling afraid in that situation. During the epidural analgesia, the puncture was administered by three different people, two of whom were student trainees. The medical records indicate that “the puncture was ‘challenging’ and caused bleeding, and the catheter had to be reinserted into the spine several times”.³ The author states that “they touched my spine, below the waist ... the second attempt was followed by a few giggles. Meanwhile, the other women, who I suppose were students [...] made very inappropriate comments”. During 10 attempts at the puncture, she heard the trainer correcting the students before finally deciding to perform the lumbar puncture herself.

¹ From the Study Centre for Human Rights and Humanitarian Law of the Panthéon-Assas University (Paris).

² See medical records in the administrative file.

³ See medical records, “haematic puncture, reinsertion”.

2.4 At around 11 p.m., when she had dilated to 8 centimetres and had a completely normal cardiocography reading, a midwife told her that she would be transferred to a delivery room as soon as they had finished with the preceding woman in labour: “You have a very elastic perineum, so you won’t have any trouble. When you feel a contraction, push. They’re going to get you ready to go to a delivery room”. Subsequently, she overheard a conversation where it was stated that the delivery rooms were overcrowded. In light of this, she refused to undergo surgery and asked her husband not to sign anything. The author reports that, on the way to the operating theatre, she felt the urge to push and was told, “Look, she’s here. Why did they send you?”. Her refusal to undergo surgery was ignored and she was transferred to the operating room where her daughter was delivered by caesarean section. The author states that she was experiencing a great deal of pain around the surgical site from the caesarean section and in the area of the lumbar puncture, but there is no indication in the medical records that she was seen for pain or given any pain medication. After the operation, the author presented “intolerance to activity” and “generalized weakness” and expressed “feelings about the loss”. “Grief facilitation” and “emotional support” were recommended to her. She also mentioned “being in great pain and not wanting to move”.⁴ When leaving the hospital, she could hardly walk, fell frequently and required the help of others, and presented with acute pain in her abdomen,⁵ insomnia and anxiety. She was prescribed anxiety medication and remained on extended sick leave.⁶

2.5 During the post-partum period, the author reportedly suffered from neck and lower back pain: “bilateral deep tendon hyporeflexia in the lower limbs and claudication when standing upright on the heels and on tiptoes”, “probably spinal/radicular in origin”.⁷ All the professionals she consulted ruled out pre-existing pathological findings in the cervical spine and skull that could explain her conditions and noted that the only correlation was the epidural punctures performed when the epidural analgesia was administered during her delivery.⁸ In this regard, the gynaecology and obstetrics expert indicated in her report that the neuropathic damage was caused by poor technical insertion of the epidural catheter into the spine, “because the person or persons lacked experience, or they were experienced, but incompetent”.⁹

2.6 With regard to psychological suffering, the psychiatrist consulted by the author stated that she found that the author was “constantly crying and tortured by flashbacks of the birth, which she would visualize in her mind practically all the time”, owing to the “terror she had experienced both for herself and for her daughter, and the mistreatment, consisting of mockery, lack of attention and abandonment, she had suffered, to the point of wanting to flee practically naked, as she was only wearing a hospital gown that was open at the back”.¹⁰ The specialist concluded that the author was suffering from post-traumatic stress disorder and indicated that “there is no doubt that the events she experienced during the birth of her daughter are sufficient to have caused the condition from which she is suffering. Given the tortuous and slow progress of her recovery, I seriously doubt that she will ever fully recover.”¹¹

⁴ Medical history record, nursing notes concerning the post-partum period.

⁵ Application to Administrative Court No. 8 of Seville. Regular proceeding 69/2012.

⁶ Ibid.

⁷ Medical assessment by the neurology specialist at the Virgen de la Macarena hospital, 11 December 2009, 20 May 2010 and 7 April 2011.

⁸ Medical reports attached as annexes to the application filed with the Administrative Court.

⁹ Medical expert report by the obstetrics and gynaecology specialist, 26 April 2012.

¹⁰ Expert medical report by psychiatry specialist, 4 May 2012.

¹¹ Ibid.

2.7 On 4 January 2010, the author filed a claim invoking financial responsibility¹² with the public health service, alleging malpractice during her delivery, primarily in the administration of epidural analgesia, the irregular practice of this procedure, the inappropriate performance of the caesarean section and the lack of informed consent to perform the caesarean section.

2.8 In the absence of a response from the administration, on 10 May 2012, the author formally submitted an application to Administrative Court No. 8 of Seville against the presumed dismissal of her claim invoking financial responsibility, in which she claimed to have been ignored as a rational subject, abandoned, humiliated and mistreated, and that she was suffering from physical and psychological conditions that were the direct consequence of scientific, legal and interpersonal abuse by the persons attending to her at the Virgen del Rocío hospital in Seville. In her application, the author states that there had been violations of: (a) her personal dignity, since she was used as a teaching tool and subjected to 10 dangerous and painful lumbar punctures; and (b) her right to physical and mental integrity, since major abdominal surgery was performed on her contrary to her express wishes and with the use of violence; she was ignored as a patient, a person, a mother and a subject endowed with reason and conscience; she was not attended to when she was in pain as a result of a hiatal hernia; and she was denied post-operative analgesia. The author attached to her application an expert report by a psychiatry specialist and an expert report by a gynaecology and obstetrics specialist which concluded that malpractice had occurred in the care provided and that alternatives to the caesarean section had been available. The administration of the hospital claimed that a caesarean section had been performed because the dilation had “stalled” but did not provide any evidence to support this claim or to justify the urgency based on a risk to the health of the mother or the fetus. In this regard, the expert cited by the author stated that “*lex artis* requires a professional faced with a challenge in the course of delivery to decide which action to take from the least adverse to the most adverse and not the other way around”. In particular, she concluded that, by disregarding the recommendations and protocols for labour care of the most reputable public health-care institutions and scientific organizations and societies, including the Good Practice Guide for Labour Care of the Andalusian Health Service itself, the health-care personnel did not comply with *lex artis* in their actions.

2.9 The author alleges that her informed consent was not obtained and that, during the administrative proceedings, the judge did not consider the documentary and expert evidence provided by the author, nor the fact that the defendants (the administration and the insurer) had not provided the information requested of them.

2.10 On 7 October 2014, the Court dismissed the author’s application.¹³ The judgment emphasized that the claim invoking financial responsibility did not focus on mistreatment of any kind, but instead concerned the alleged malpractice in the administration of epidural analgesia and the decision to perform a caesarean section, and that no claim for compensation for physical and psychological damages was made. In this regard, the Court found that there was no objective evidence of the author’s desire for a natural birth, nor of the number of attempts made to administer epidural anaesthesia, and that the medical documentation provided by the author could not serve as a basis for a claim for compensation for possible consequences of faulty administration of epidural anaesthesia. On the other hand, the Court determined that, based on the information provided in the clinical report, the “only therapeutic alternative that guaranteed the safety of the mother and the fetus was a caesarean

¹² Administrative record of the claim invoking financial responsibility submitted to the Andalusian Health Service.

¹³ First instance judgment No. 261/14, Administrative Court No. 8 of Seville, regular proceeding 69/12, 7 October 2014.

section”, noting that, “while it is true that this might not have been the birth desired by the lady, the duty of the health service to preserve the integrity and health of the mother and her child prevails over her legitimate desires, and it is the health service that, in view of this purpose and the function it performs, must make the decisions that ensure and provide the best care for her”.¹⁴ Regarding the matter of proof of informed consent, the judge determined that it “was not relevant to determining financial responsibility” since “the non-existence of an expressly signed consent form does not affect the decision to perform the caesarean section, given its urgent nature”. Lastly, the judge concluded by stating that, “while it is true that expectant mothers may express certain preferences regarding how the act of childbirth is to be carried out, it is no less true that this act is subject to the expectation that the health of both mother and child will be ensured ... Therefore, the act of informing and obtaining prior consent must be viewed in the context of the possible complications that may arise at those times.”¹⁵ Taking into account the fact that the patient was informed verbally, the Court determined that the absence of a consent form signed by the patient was not a determining cause for financial responsibility.¹⁶

2.11 On 31 October 2014, the author submitted an appeal¹⁷ to the High Court of Justice of Andalusia, claiming violation of the right to effective judicial protection. The author claimed that the evidence presented, in particular the expert opinions of the gynaecology and obstetrics specialist and the psychiatry specialist, had not been assessed. She also argued that the administration had the obligation to demonstrate that informed consent had been obtained orally or in writing and that the judge had confused the obligation of the professionals to ensure the health of the mother and child and to act in accordance with *lex artis* with an alleged right to impose any intervention deemed appropriate, without need of informing the affected person or obtaining her consent, and recalled that it is especially important to inform and involve the woman in making any decision that affects the course of her labour. She added that someone who is informed of what is happening feels that she has some control over the situation (can think, assess, ask questions, decide), and thus agrees to the interventions and can psychologically prepare to accept undesirable outcomes, and that the aim of obtaining informed consent is precisely to reduce the likelihood of developing syndromes such as post-traumatic stress disorder.¹⁸

2.12 On 20 January 2016, the High Court of Justice of Andalusia issued a judgment dismissing the appeal,¹⁹ in which it determined that communicating to the author’s husband and mother that the caesarean section was going to be performed was sufficient for the purposes of informed consent, that the decision was based on the existence of sufficient information provided to the patient and her family members, in a manner that was appropriate to the circumstances of urgency and necessity surrounding the intervention, and that the author had not presented sufficient evidence, beyond her statements, that the delivery rooms were overcrowded, which was, according to the author, what prompted the performance of the caesarean section. The Court found that the health service had offered the author and her husband information about the possible consequences of a natural delivery and that, given the urgent situation, providing information and obtaining written consent could have jeopardized the success of the operation. The Court also determined that the decision to perform a caesarean section had been based on the progression of the labour (stalled) and that the author did not establish to what extent the amniotomy or the

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Appeal of the dismissal judgment of the Administrative Court, Seville, 31 October 2014.

¹⁸ Expert medical report by psychiatry specialist, 4 May 2012.

¹⁹ Judgment of the High Court of Justice of Andalusia dismissing the appeal.

provision of oxytocin might have led to the caesarean section, nor was it demonstrated that her taking a more comfortable position could have prevented the cephalopelvic disproportion that allegedly prompted the caesarean section.

2.13 On 15 March 2016, the author submitted an application for *amparo* (protection of rights)²⁰ to the Constitutional Court alleging violation of the right to equality before the law without discrimination on the basis of sex. The author established that, by the logic of the first instance judge, the protection granted by law to patients can be disregarded in the case of expectant mothers, and that, in the case of pregnant women, it is the doctor who makes decisions without needing to include or inform the patient, which violates her dignity and privacy and relegates that violation to a merely clinical matter. The author claimed that the humiliation stemmed precisely from being disregarded as a rational subject capable of looking after her own health and that of her daughter. On 18 July 2016, the Court dismissed the application for *amparo* on the grounds that the facts lacked “particular constitutional significance”.

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

2.14 The author maintains that childbirth services in the State party are particularly interventionist,²¹ and according to testimonies by various women, degrading comments are common during labour²² and women are subjected to unnecessary medical procedures, including the abuse of oxytocics, caesarean sections and episiotomies, to accelerate labour. The author also refers to the report of the Centre for the Monitoring of Obstetric Violence, according to which, during labour, 50 per cent of women are not informed of interventions performed on them, 65.8 per cent of birth plans are not respected, 55.7 per cent of women are not allowed to eat or drink, and 74.7 per cent of women are not allowed to choose their position during the delivery.²³

2.15 The author mentions that the non-governmental organization Médecins du Monde has concluded that the number of caesarean sections and episiotomies in the State party exceed those recommended by the World Health Organization (WHO). Médecins du Monde defines obstetric violence as actions and behaviours that dehumanize and diminish women during the entire process of pregnancy, childbirth and the post-partum period, such as physical and verbal mistreatment, humiliation, lack of information and consent, the abuse of medicalization and the pathologization of natural processes, and that lead to loss of freedom, autonomy and the ability to freely make decisions concerning their body and sexuality.²⁴

2.16 The author maintains that the asymmetrical relationship between women and health professionals leads to an added inequality that results from the doctor-patient hierarchy, in which professionals appropriate a position of knowledge and power

²⁰ Application for *amparo* submitted to the Constitutional Court, 15 March 2016.

²¹ See Adela Recio Alcaide, “La atención al parto en España: cifras para reflexionar sobre un problema” (Care during childbirth in Spain: figures to reflect on a problem), *Dilemata*, year 7, No. 18 (2015), pp. 13–26.

²² See *N. A. E. v. Spain* (CEDAW/C/82/D/149/2019), paras. 2.24 to 2.32 and *S. F. M. v. Spain* (CEDAW/C/75/D/138/2018).

²³ See the results of the surveys carried out by the Centre for the Monitoring of Obstetric Violence, available at <https://www.elpartoesnuestro.es/sites/default/files/public/OVO/informeovo2016.pdf>; and Cristina Medina Pradas and Paz Ferrer Ispizua, “Prevalence of obstetric violence in Spain”, infographic, 2017, available at <https://azucenamanzanares.com/wp-content/uploads/VO.pdf>.

²⁴ See *N. A. E. v. Spain* (CEDAW/C/82/D/149/2019), paras. 2.24 to 2.32 and *S. F. M. v. Spain* (CEDAW/C/75/D/138/2018).

through such actions.²⁵ This reduces women's ability to take care of themselves and makes them dependent on a technical medical intervention.²⁶

2.17 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.

2.18 In this regard, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has noted that obstetric violence results in physical and psychological suffering that can constitute ill treatment.²⁷

2.19 The author notes that obstetric violence was recognized as such in 2014 by WHO, which stated that "many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination."²⁸

Complaint

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

3.2 The author claims that her rights under articles 2, 3, 5 and 12 of the Convention were violated when she did not receive adequate medical care during and after her labour, either from a clinical point of view or in respect of the exercise of her right to consent to or refuse the medical interventions to which she was subjected. The author further alleges that she was not informed, her consent was not sought and she was not taken into consideration when decisions were made regarding her early admission, the artificial rupture of the amniotic sac, the administration of synthetic oxytocin, the administration of epidural anaesthesia and the performance of a caesarean section. She was forced to remain in the lithotomy position even though she had a hiatal hernia. She was subjected to a challenging epidural anaesthesia that resulted in 10 painful punctures, the physical effects of which she is still suffering today. The benefits and risks of these interventions were not explained to her, nor was she offered alternatives. As a result of this, she experienced physical and psychological consequences. Her right to be informed and to freely consent to or refuse medical interventions is recognized in the policies set out in the Project to Humanize Perinatal Care in Andalusia. However, the State party did not penalize the alleged violations, nor did it guarantee effective protection, either through the national courts or through any other type of institution, thus stripping public policy of all effectiveness and permitting the systematic abuse of power over pregnant women.

3.3 Regarding the violation of article 2, read in conjunction with articles 1, 3, 4, 5 and 24 of the Convention, the author argues that the type of discrimination she experienced is based on gender, because the consent required for interventions performed during labour can only be given by women, who have the status of parturient, mother and client. In this respect, major abdominal surgery was performed without her informed consent, in violation of articles 2 and 3.

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

²⁶ See Marbella Camaraco, "Patologizando lo natural, naturalizando lo patológico. Imprints de la praxis obstétrica" (Pathologizing the natural, naturalizing the pathological: Impressions from obstetric praxis), *Revista venezolana de estudios de la mujer*, vol. 14, No. 32 (2009).

²⁷ See [A/HRC/31/57](#), para. 47.

²⁸ See WHO, document WHO/RHR/14.23.

3.4 Regarding the violation of article 5 of the Convention, the author alleges that the poor care she received was due to the prevalence of gender stereotypes, which is reflected in women's lack of autonomy regarding their decisions about sexual health, maternity and childbirth, based on a paternalistic vision and authoritarian model of the doctor-patient relationship in which an individual, simply because she is pregnant, is stripped of her status as a rational subject, depriving her of the ability to decide her own destiny. The model of free will regulated in the General Health Act provides that persons in full use of their mental faculties are capable of deciding for themselves if they are given information that is accurate and suited to their needs. The author adds that, in its judgment, the first instance court stated that expectant mothers only have the right to "express certain preferences regarding how the act of childbirth is to be carried out", sending the message that pregnant women cannot make good, fair and wise decisions to protect themselves and their children, and concluded that expectant mothers must remain under the guardianship of a doctor – as if they were minors – and that the moral autonomy guaranteed to all other persons by law does not apply to them. That is because, for pregnant women, free and informed decisions do not exist, instead, they have simple "preferences" (predilections, whims, cravings), which are based on enduring gender stereotypes regarding how women should behave in relation to maternity. Denying women the capacity to make free decisions about their own health and their own bodies and those of their future children, and attributing this capacity to doctors, reflects the idea that women are inferior. The State party has therefore failed in its obligation to change these patterns in the area of obstetric care, in violation of article 5 (a) of the Convention.

3.5 Additionally, the author claims that at no point were the authorities capable of fully understanding the causes and effects of the phenomenon of obstetric violence as a form of gender-based violence and possible violation of women's human rights. In order for women to have full and equal access to justice, the State party should, in addition to guaranteeing equal access to justice in its laws and policies, ensure that those laws and policies are protected without promoting gender stereotypes. Such stereotypes centre on women's role as a reproductive vessel and are manifested when their consent is discounted. The set of prejudices regarding how a woman in labour should behave and the trivialization of the author's physical and spiritual health led to her injuries and other impacts being minimized, the other party being granted greater credibility and the author being prevented from accessing effective judicial protection.

3.6 Regarding the violation of articles 2 and 12 of the Convention, the author claims that the treatment she received constitutes a violation of her right to sexual and reproductive health and her right to receive safe, high-quality maternity care that is free from discrimination and violence. Permitting discriminatory attitudes based on gender stereotypes is a violation of the Convention;²⁹ she claims that the medical care, on the one hand, and the subsequent legal proceedings, on the other hand, demonstrate that the State party has not complied with its obligations to protect women from discrimination and violence during pregnancy, childbirth and the post-partum period. As a result of the injuries sustained during childbirth, the author suffered neuropathic damage and post-traumatic stress disorder, for which she underwent intensive treatment.

3.7 The author requests individual reparation for the violations suffered, as well as the following measures of non-repetition: implementation of awareness-raising campaigns on gender equality and violence against women to combat stereotypes

²⁹ The author cites general recommendation No. 27 (2010) on older women and protection of their human rights, and general recommendation No. 28 (2010) on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women.

associated with maternity; preparation of studies and statistics to combat and raise awareness of obstetric violence; and training of the judiciary and the public health system on violence against women, particularly obstetric violence. The author also requests the Committee to draw up a general recommendation on obstetric violence, since it is a practice from which women are suffering worldwide.

State party's observations on admissibility and the merits

4.1 On 23 June 2020 and 14 October 2021, the State party submitted its observations on admissibility and the merits. The State party argues that the communication is inadmissible because it has been submitted to another international procedure; the author filed an application with the European Court of Human Rights. That application was declared inadmissible on 13 April 2017³⁰ after an exhaustive analysis of both procedural and substantive requirements was conducted and the counsel of the Registry of the Court, acting as rapporteurs, prepared a report which was adopted by a single judge.

4.2 The State party claims that the communication is inadmissible because the author is seeking a review of the assessment of the evidence conducted by the courts, which carried out an exhaustive assessment of the evidence.

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

4.4 As to the merits, the State party maintains that the Convention was not violated because the assessment of the evidence was not arbitrary, no manifest error was made and justice was not denied.

4.5 In addition, the State party emphasizes that no complaints concerning the present case were made to the hospital and the author did not file her claim invoking financial responsibility until a year after the events. Furthermore, that claim does not mention obstetric violence in any way, nor any violation of the right to physical integrity or of the right to personal and family privacy, nor any violation of the principle of equality. Instead, the claim is limited to setting forth the grounds for asserting a breach of *lex artis* by the hospital, and it was not until the proceedings before the administrative court that the author provided a report prepared by an obstetrician-gynaecologist and another by a psychiatrist.

4.6 Lastly, the State party indicates that the author did not allege a violation of the right to equality until she lodged the appeal, and this was also when the word "violence" appeared for the first time.

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

³⁰ Application to the European Court of Human Rights and letter from the European Court of Human Rights rejecting the application.

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

5.1 On 28 August 2020 and 15 December 2021, the author submitted her comments on the State party's observations and indicated that, in accordance with Protocol No. 14 to the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights), a single judge may declare an application inadmissible when it is determined that it does not meet the basic requirements of admissibility, in which case "further examination" is not required. The author adds that a communication has been examined when the merits of the case have been considered and, based on the Committee's jurisprudence, a case should not be deemed to have been examined by the European Court of Human Rights when it has been declared inadmissible on procedural grounds. According to the jurisprudence of the Human Rights Committee, "the limited reasoning contained in the Court's letter" does not allow for the assumption "that the examination included a sufficient consideration of the merits".³¹

5.2 The author states that her communication does not seek merely to challenge the findings of the national authorities, but also to have the proceedings reviewed on the grounds of denial of justice and gender-based discrimination resulting from the stereotypes present in health and judicial institutions. She recalls that this Committee has stated in its jurisprudence that "it is generally for the authorities of States parties to the Convention to evaluate the facts and evidence and the application of national law in a particular case, unless it can be established that the evaluation was conducted in a manner that was biased or based on gender stereotypes that constitute discrimination against women, was clearly arbitrary or amounted to a denial of justice".³² The author adds that the patterns of discrimination against women in the State party affected the exercise of her rights and that, simply because she was a woman and pregnant, she had been prevented from obtaining redress for those violations before the national courts, owing to the inadequate implementation of existing laws and policies at the national level.

5.3 With respect to the assessment of the evidence, the author states that her appeal and application for amparo focused on the violation of the principle of immediacy, the loss of a defence and the automatic nullity of the judicial conduct of the first instance court, given that it did not conduct an exhaustive assessment of the evidence, completely disregarded the expert report on gynaecology and obstetrics provided, did not mention the applicable reproductive health guides and protocols, and ignored the matter of informed consent, arbitrarily replacing the right to make free and informed decisions with the ability to "express certain preferences", which does not imply participation in the making of any decision that affects the course of labour.³³

5.4 Concerning the State's allegations that violations of fundamental rights were not alleged in the domestic proceedings, the author recalls the Committee's jurisprudence, in which the Committee determined that a complainant need not have denounced before the State jurisdiction a specific violation of a right on the basis of a provision of the corresponding instrument, but only the violation of the guaranteed right, and that, even if no express claim of sex-based discrimination was raised before the domestic bodies, it is understood that, to the extent that sexist violence or physical or psychological abuse suffered by a woman because she is a woman has been

³¹ See *Achabal Puertas v. Spain* (CCPR/C/107/D/1945/2010), para. 7.3.

³² See *S.F.M. v. Spain* (CEDAW/C/75/D/138/2018), para. 6.4.

³³ Judgment of Administrative Court No. 8 of Seville. Regular proceeding 69/2012, 7 October 2014.

revealed, the authorities had the opportunity to examine those allegations.³⁴ The author reiterates that throughout the domestic proceedings it was argued that the rights violations to which she was subject were rooted in discrimination and a lack of implementation of regulations and standards on women's sexual and reproductive health.³⁵ The author adds that, as determined by this Committee, in cases of gender-based violence, which includes obstetric violence, discrimination is presumed and therefore does not need to be expressly mentioned.

5.5 With regard to the allegation that the procedure selected for the purpose of upholding her rights is inappropriate, the author recalls that the purpose of the requirement that domestic remedies be exhausted is to ensure that States parties have the opportunity to remedy a violation. In the same vein, this Committee has established that the requirement to exhaust domestic remedies is intended to ensure "that States parties have an opportunity to remedy a violation of any of the rights set forth under the Convention through their legal systems before the Committee considers the violation".³⁶ If more than one possible effective remedy is available, victims may select the one they consider most appropriate.³⁷ The author argues that she pursued legal and legitimate ways of exhausting domestic remedies, in which she expressly invoked the violation of her rights to physical and psychological integrity, to personal and family privacy and to receive information and decide freely, having made the argument as to why the acts to which she was subject constitute discrimination based on gender and sex.

5.6 Regarding the State's argument that there is no record of any complaint to the hospital and that the author did not set out the sum for compensation in her claim, the author indicates that the fact that she did not lodge regular complaints with the hospital is irrelevant since she filed a claim invoking financial liability within the time limit, and in that claim she expressly complained that there had been irregularities in the administration of epidural anaesthesia, that a caesarean section had been performed on her because the delivery rooms were overcrowded and that this had been done despite her opposition. As to the State party's argument that the assessment of the evidence during the judicial process was "exhaustive", the author argues that the conclusions of the specialists were ignored and the assessment had relied solely on the statements of the health services involved.

5.7 Concerning the matter of informed consent, although the State party refers to the arguments of the judicial officers who determined that the "urgent" situation constituted an exception to the requirement of obtaining informed consent and documenting it in writing, the actual law on patient autonomy³⁸ establishes that the consent requirement may be waived under the following circumstances: (a) when there is an immediate serious risk to the physical or psychological integrity of the patient, and (b) when it is not possible to obtain the patient's authorization. These circumstances were not applicable in this case, and furthermore, the judicial bodies did not verify whether there had been compliance with the requirements established by law. The author recalls that the Committee provided in its general recommendation 24 (1999), on women and health, that: "Acceptable services are

³⁴ See *N. v. Netherlands* (CEDAW/C/57/D/39/2012), para. 6.4.

³⁵ Application to Administrative Court No. 8 of Seville. Regular proceeding 69/2012.

³⁶ The author cites *Rahime Kayhan v. Turkey* (CEDAW/C/34/D/8/2005), paras. 7.5–7.7; *Goekce v. Austria* (CEDAW/C/39/D/5/2005), para. 7.2; *Zhen Zheng v. Netherlands* (CEDAW/C/42/D/15/2007), para. 7.3; and *N.S.F. v. United Kingdom* (CEDAW/C/38/D/10/2005), para. 7.3.

³⁷ The author cites *Moreira Barbosa v. Portugal* (application No. 65681/01), judgment of 29 April 2004; *Jeličić v. Bosnia and Herzegovina*, (application No. 41183/02), judgment of 31 October 2006.

³⁸ See Patient Autonomy Act, article 9.2.

those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.”³⁹ The author adds that the Special Rapporteur on violence against women, its causes and consequences, Dubravka Šimonović, stressed that “the health provider has the power of authoritative medical knowledge and the social privilege of recognized medical authority, while the woman is largely dependent on the provider for information and care. A woman during childbirth is also particularly vulnerable.”⁴⁰ She also stated that, “when practiced without a woman’s consent, caesarean sections may amount to gender-based violence against women and even torture”.⁴¹

5.8 The author states that her call for measures aimed at eliminating systemic and structural obstetric violence in the State party does not distort the purpose or objective of the Optional Protocol. Additionally, she reiterates that it is crucial to make transformative reparations that offer a guarantee of non-repetition.

Third-party intervention

6.1 On 2 June 2020, the Study Centre for Human Rights and Humanitarian Law of the Panthéon-Assas University recalled that the Special Rapporteur on violence against women, its causes and consequences, uses the term “obstetric violence” to refer to violence suffered by women when receiving labour care. The submitter argues that obstetric violence is a reflection of entrenched gender discrimination in the health sector, aggravated by the fact that men are overrepresented in the field of obstetrics and gynaecology.

6.2 The submitter argues that, in order to prevent obstetric violence, States have obligations relating to the treatment of women in delivery rooms, such as the obligation to eradicate customs and practices that perpetuate the notion of women’s inferiority through awareness-raising programmes for medical services and the obligation to guarantee women’s full informed consent.

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

Issues and proceedings before the Committee

Consideration of admissibility

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

7.2 The Committee recalls that, under article 4 (2) (a) of the Optional Protocol, it is precluded from declaring a communication admissible when the same matter has been or is being examined under another procedure of international investigation or

³⁹ See general recommendation No. 24 (1999) on women and health.

⁴⁰ See the report of the Special Rapporteur on violence against women, its causes and consequences, Dubravka Šimonović, on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth care and obstetric violence ([A/74/137](#)), 11 July 2019, para. 49.

⁴¹ *Ibid.*, para. 24.

settlement.⁴² The Committee notes the State party's observation that the author filed an application with the European Court of Human Rights on 26 January 2017, on her own behalf, under articles 3, 6 (1), 8 and 13, in conjunction with article 14, of the European Convention on Human Rights, and that this application was declared inadmissible by the Court on 13 April 2017 as it failed to comply with the admissibility criteria set out in articles 34 and 35 of the European Convention on Human Rights. The Committee recalls its jurisprudence according to which the "same matter" within the meaning of article 4 (2) (a) of the Optional Protocol must be understood as relating to the same author, the same facts and the same substantive rights.⁴³ The Committee notes that the author's application to the European Court of Human Rights was based on the same facts and concerned the same substantive rights as those raised in the present communication. The Committee must therefore determine whether the Court "considered" the same matter, within the meaning of article 4 (2) (a) of the Optional Protocol. The Committee recalls its jurisprudence according to which, when the European Court of Human Rights has based a declaration of inadmissibility not solely on procedural grounds but on reasons that include a certain consideration of the merits of the case, however limited, then the same matter has been "examined" within the meaning of the reservations to article 4 (2) (a) of the Optional Protocol.⁴⁴ In the present case, the Committee notes that the brevity of the Court's decision makes it impossible for it to determine with certainty whether the Court considered the merits of the case, even in a limited way.⁴⁵ Accordingly, the Committee considers that it is not precluded from examining the present communication under article 4 (2) (a) of the Optional Protocol.

7.3 The Committee takes note of the State party's argument that the communication is inadmissible because domestic remedies have not been exhausted, since the author did not submit a claim on the grounds of violation of her fundamental rights but rather a claim invoking financial responsibility, followed by an administrative application and an application for *amparo*. The Committee also takes note of the author's claim that the remedy she pursued is a legitimate legal means of exhausting domestic remedies. In this connection, the Committee recalls that the authors of an individual communication are not obliged to exhaust all available remedies but must give the State party the opportunity, through a relevant chosen mechanism, to remedy the matter raised within its jurisdiction.⁴⁶ The Committee notes that the author raised before the domestic courts all the issues before it regarding the alleged obstetric violence she suffered, and that she has exhausted administrative remedies as well as appeal and *amparo* procedures. Accordingly, the Committee considers that the author pursued an approach that appeared relevant to satisfy her claims before the Committee and concludes that domestic remedies have been exhausted for the purposes of article 4 (1) of the Optional Protocol.⁴⁷

⁴² See *T.N. v. Denmark* (CEDAW/C/59/D/37/2012), para. 12.4; *Trébutien v. France* (CCPR/C/51/D/421/1990), para. 6.3; and *Petersen v. Germany* (CCPR/C/80/D/1115/2002), para. 6.3.

⁴³ See *Kayhan v. Turkey* (CEDAW/C/34/D/8/2005), para. 7.3, and *Petersen v. Germany* (CCPR/C/80/D/1115/2002), para. 6.3.

⁴⁴ See *Bertelli Gálvez v. Spain* (CCPR/C/84/D/1389/2005), para. 4.3; *Wdowiak v. Poland* (CCPR/C/88/D/1446/2006), para. 6.2; *Alzery v. Sweden* (CCPR/C/88/D/1416/2005), para. 8.1; and *Quliyev v. Azerbaijan* (CCPR/C/112/D/1972/2010), para. 8.2.

⁴⁵ See communications Nos. 1945/2010, *Achabal Puertas v. Spain*, para. 7.3, and 2474/2014, *X. v. Norway*, para. 6.2.

⁴⁶ See *T.N. v. Denmark* (CEDAW/C/59/D/37/2012), para. 12.4; *Onoufriou v. Cyprus* (CCPR/C/100/D/1636/2007), para. 6.2; and *Vojnović v. Croatia* (CCPR/C/95/D/1510/2006), paras. 7.1 and 7.2.

⁴⁷ See *S.F.M. v. Spain* (CEDAW/C/75/D/138/2018), para. 6.3.

7.4 The Committee notes the State party's argument that the communication is inadmissible because the author is seeking a review of the domestic courts' assessment of the facts and evidence. The Committee also notes the author's claim that she is not seeking a review of the evidence or that a retrial be ordered, but that she presented all the facts and evidence to argue that the legal proceedings in her case were imbued with gender stereotypes regarding childbirth, which distorted the discernment of the judicial authorities. The Committee further notes the author's claim that the judicial authorities did not take into account the various pieces of expert evidence she provided throughout the proceedings. The Committee considers that the allegations, which relate to the denial of justice and gender-based discrimination resulting from stereotypes, are directly related to the merits of the communication and therefore concludes that it has the power to examine the present communication and thus to determine whether there was any irregularity in the judicial process in relation to the obstetric violence alleged by the author.⁴⁸

Consideration of the merits

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

7.6 The Committee notes that, according to the author, the cascade of interventions that culminated in a caesarean section without her consent having been properly sought (paras. 2.1–2.6), the unresolved neurological consequences and neuropathies and, finally, the post-partum post-traumatic stress disorder she suffered were owing to structural discrimination based on gender stereotypes surrounding childbirth, and that these stereotypes also shaped the response of the administrative and judicial authorities when they failed to consider the lack of respect for the appropriate protocols or to evaluate the reports that the author provided to prove malpractice, including the diagnosis of post-partum post-traumatic stress disorder. The Committee notes that the author claims that her rights to sexual and reproductive health and to access to safe and high-quality maternity services free from discrimination and violence were violated. The Committee also notes that, according to the State party, the caesarean section was performed once the labour was considered to have stalled and that the judge established, after an exhaustive assessment, that the absence of an expressly signed consent form did not affect the decision to perform the caesarean section, given its urgent nature. The Committee takes note of the author's argument that the judge did not consider that it had been necessary to obtain her informed consent, that expectant mothers are only allowed to express "certain preferences" in relation to childbirth and that deciding how a delivery will occur is exclusively the role of the medical professional, thus infringing upon the author's autonomy and dignity and failing to recognize her as a subject capable of looking after her health and that of her daughter.

7.7 The Committee recalls that quality health-care services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.⁴⁹ It also recalls that women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives.

7.8 The Committee notes that, although there is still no official definition of "obstetric violence", the Special Rapporteur on violence against women, its causes

⁴⁸ See *N.A.E. v. Spain* (CEDAW/C/82/D/149/2019), para. 14.4.

⁴⁹ See general recommendation No. 24 (1999), on women and health.

and consequences uses the term “obstetric violence” to refer to violence against women experienced during facility-based childbirth and affirms that this form of violence has been shown to be widespread and systematic in nature, or ingrained in health systems.⁵⁰ According to the Special Rapporteur, it is part of a continuum of the violations that occur in the wider context of structural inequality, discrimination and patriarchy, and also the result of a lack of proper education and training, as well as a lack of respect for women’s equal status and human rights.⁵¹ Particularly relevant to the present communication are the Special Rapporteur’s assertions that a caesarean section performed without the woman’s consent,⁵² and the use of inexperienced medical staff to carry out gynaecological examinations,⁵³ are acts that may amount to obstetric violence. Also of particular relevance is her assertion that informed consent for medical treatment related to reproductive health services and childbirth is a fundamental human right. Women have the right to receive full information about recommended treatments so that they can make well-considered and informed decisions.⁵⁴

7.9 The Committee recalls that, in its concluding observations, it has recommended that States parties adopt “legal and policy measures to protect pregnant women during childbirth, sanction obstetric violence, strengthen capacity-building programmes for medical practitioners and ensure regular monitoring of the treatment of patients in health-care centres and hospitals”.⁵⁵ In its examination of individual communications, the Committee has also ruled on facts similar to those in the present case, related to the same context in the same State party, finding violations of articles 2 (b), (c), (d) and (f), 3, 5 and 12 of the Convention.⁵⁶

7.10 The Committee recalls that it is generally for the authorities of States parties to evaluate the facts and evidence and the application of national law in a particular case, unless it can be established that the evaluation was conducted in a manner that was biased or based on gender stereotypes that constitute discrimination against women, was clearly arbitrary or amounted to a denial of justice.⁵⁷ In the present communication, the Committee must assess the State party’s compliance with its obligation to exercise due diligence in the administrative and judicial proceedings initiated because of the acts that are the subject of the author’s complaint and with a view to ending gender stereotypes. In this regard, the Committee notes that, according to the State party, the administration and the domestic courts thoroughly assessed the reports submitted and that, in her administrative complaint, the author only alleged malpractice and not obstetric violence, meaning that it had not been possible for the administration and domestic courts to rule on the latter. The Committee notes, however, the author’s allegation that, to the extent that there was evidence of physical or psychological mistreatment suffered by a woman, because she was a woman, the authorities had the opportunity to examine these allegations. The Committee also notes that the judge did not take into account the disregard for the appropriate protocols, the absence of informed consent forms or the reports that the author provided during the proceedings to prove malpractice, in particular the expert report of a specialist in gynaecology and obstetrics. Neither did the judge take into account

⁵⁰ [A/74/137](#), paras. 4, 12 and 15.

⁵¹ *Ibid.*, para. 9.

⁵² *Ibid.*, para. 24.

⁵³ *Ibid.*, para. 26.

⁵⁴ *Ibid.*, para. 32.

⁵⁵ See [CEDAW/C/CRI/CO/7](#), para. 31.

⁵⁶ See *N.A.E. v. Spain* ([CEDAW/C/82/D/149/2019](#)), para.15.5, and *S.F.M. v. Spain* ([CEDAW/C/75/D/138/2018](#)), paras. 7.5 and 7.6.

⁵⁷ See *H.D. v Denmark* ([CEDAW/C/70/D/76/2014](#)), para. 7.7.

the reports submitted relating to the diagnosis of post-partum post-traumatic stress disorder.

7.11 The Committee also notes the author's argument that the administrative and judicial authorities gave greater weight to the hospital's reports and made assumptions based on gender stereotypes. The Committee notes that, according to the gynaecological and obstetric clinical reports provided by the author, the medical personnel did not comply with *lex artis*: the protocols were not followed, the amniotic sac was ruptured and oxytocin was prescribed without the need for doing so having been justified, the history of hiatal hernia was ignored, epidural anaesthesia involving 10 punctures was administered, and a diagnosis of stalled labour was made without considering alternatives to a caesarean section. The Committee notes the author's argument that the medical records do not contain consent forms for the caesarean section, which are required under the Patient Autonomy Act, or any indication that the reasons for, risks of and consequences of performing the procedure were explained. As the reports make clear, had the applicable standards and protocols been followed, the author would very likely have experienced a normal birth. The Committee notes that the national authorities did not conduct an exhaustive analysis of this evidence for the present case, nor did they request the preparation of a legal expert opinion to support the conclusion that the induction and subsequent caesarean section were practices in accordance with *lex artis*. On the contrary, the judge established that the question of proof of informed consent "was not relevant to determining financial responsibility" since the non-existence of an expressly signed consent form did not affect the decision to perform the caesarean section, given its urgent nature. The Committee also notes, with regard to the post-partum post-traumatic stress disorder, that the humiliation suffered by the author stemmed precisely from not being treated as a subject capable of looking after her health and that of her daughter. It also notes that the State party did not submit any arguments concerning this point.

7.12 The Committee considers that the cumulative facts of the present case, in particular, the loss of dignity, the abuse and the mistreatment suffered by the author, the failure to consider pre-existing conditions, the irregular application of epidural anaesthesia without obtaining informed consent and/or without having justified the need for such interventions, and the failure to obtain informed consent prior to performing a caesarean section, all of which had physical and psychological consequences for the author, constitute obstetric violence.⁵⁸

7.13 In this context, the Committee recalls that, under articles 2 (f) and 5, States parties have the obligation to take all appropriate measures to modify or abolish not only existing laws and regulations but also customs and practices that constitute discrimination against women.⁵⁹ The Committee considers that gender stereotyping affects the right of women to be protected against gender-based violence, including obstetric violence, and that the authorities responsible for determining responsibility for such acts should exercise particular caution in order not to reproduce gender stereotypes.⁶⁰ The Committee notes that, in the present case, the administrative and judicial authorities of the State party applied stereotypical and therefore discriminatory notions of gender, for example, by assuming that it is the doctor who decides whether or not to perform a caesarean section, without exploring alternatives, explaining the reasons to the patient or seeking her informed consent, even though the author had expressed her opposition to the procedure.

⁵⁸ See *N.A.E. v. Spain* (CEDAW/C/82/D/149/2019), para. 15.7.

⁵⁹ See *González Carreño v. Spain* (CEDAW/C/58/D/47/2012), para. 9.7.

⁶⁰ See Inter-American Court of Human Rights, *Advisory Opinion OC-29/22*, 30 May 2022, Differential approaches to certain groups of persons deprived of liberty, para. 160.

7.14 Consequently, acting under article 7 (3) of the Optional Protocol, the Committee is of the view that the facts before it reveal a violation of the rights of the author under article 2, read in conjunction with articles 1, 3, 5 and 24; and articles 3, 5 and 12 of the Convention.

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

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

(b) General:

(i) Ensure that women have access to adequate health-care services during pregnancy, childbirth and the post-partum period, and that they are protected from mistreatment, disrespect and abuse during childbirth in health-care institutions;

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

(iii) Ensure that staff working in public and private health-care institutions comply with the obligations set out in subparagraphs (i) and (ii) of the present recommendations;

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

(v) Provide obstetrician-gynaecologists and other health-care workers with adequate professional training in reproductive health and health-care services;

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

(vii) Carry out awareness-raising campaigns on gender equality and gender-based violence against women in order to combat gender stereotypes, such as those related to maternity and women's reproductive role;

(viii) Draft, publish and implement a "patients' bill of rights" relating to reproductive health;

(ix) Provide adequate professional training to the judiciary and public and private health-care providers to enable them to recognize the different forms of gender-based violence against women, including obstetric violence;

(x) Promote a public dialogue, with media participation, about women's human rights in general, gender-based violence against women and, in particular, obstetric violence;

(xi) Review its existing legislation on gender-based violence against women with a view to including other forms of gender-based violence,⁶¹ such as obstetric violence.

9. In accordance with article 7 (4) of the Optional Protocol, the State party shall give due consideration to the views of the Committee, together with its recommendations, and shall submit to the Committee, within six months, a written response, including information on any action taken in the light of the views and recommendations of the Committee. The State party is also requested to publish the Committee's views and recommendations and disseminate them widely in order to reach all sectors of society.

⁶¹ See [CEDAW/C/ESP/CO/7-8](#) (CEDAW 2015), para. 21.