Edited by
Marilisa D'Amico,
Costanza Nardocci

OB-GYN VIOLENCE

Italy, Europe, and Canada

IDN
I DIRITTI NEGATI

RICERCHE

FrancoAngeli

COLLANA DIRETTA DA
GUSTAVO ZAGREBELSKY
MARILISA D'AMICO

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Collana diretta da
Gustavo Zagrebelsky
e Marilisa D'Amico

I diritti umani non sono astratte prove di sentimentalismo umanitario. Hanno, dalla loro parte, grandi visioni del mondo e concezioni filosofiche. Ma queste non sarebbero che esercitazioni o elucubrazioni teoriche se non si fossero incarnate in potenti movimenti sociali di rivendicazione di libertà e giustizia.
Si è trattato d'una storia plurisecolare della libertà come liberazione. I suoi protagonisti concreti sono state le forze di coloro che stavano al basso della piramide sociale, non avendo, quelli che stavano in alto, bisogno di diritti, poiché a loro bastavano i poteri. Si è trattato anche della storia dell'uguaglianza. Senza uguaglianza, infatti, i diritti cambiano natura: per coloro che stanno in alto, diventano privilegi e, per quelli che stanno in basso, carità; ciò che è giustizia per i primi è ingiustizia per i secondi; la solidarietà si trasforma in invidia sociale; le istituzioni, da luoghi di protezione e integrazione, diventano strumenti di oppressione e divisione. Senza uguaglianza, il regime dei diritti – la democrazia – diventa oligarchia: i diritti di partecipazione politica diventano armi nelle mani di gruppi potere, e i diritti sociali diventano concessioni condizionate al beneplacito di chi è nelle condizioni di poterne fare meno. Di questa funzione emancipatrice dei diritti umani si è in gran parte persa la consapevolezza. E ciò è potuto accadere proprio in conseguenza della loro diffusione, che ha messo in secondo piano il loro diverso significato, e ne ha fatto perdere la forza contestatrice delle situazioni e delle istituzioni della disuguaglianza. Oggi, però, di fronte al riapparire di profonde divisioni e di gravi discriminazioni nelle compagini umane, derivanti da cause complesse, occorre riprendere i discorsi sui diritti rimettendo in primo piano il loro significato originario.
Questa è la prospettiva della Collana di studi che si propone: un approfondimento dello studio dei diritti umani nelle situazioni della vita in cui singoli individui e gruppi sociali (detenuti, ammalati, portatori di handicap, emigrati, minoranze d'ogni genere) soffrono discriminazioni a causa delle loro particolarità individuali e della loro posizione nella organizzazione sociale.
La Collana comprende distinti contributi scientifici suddivisi in tre sezioni: atti di seminari e convegni (ATTI), raccolte di materiali e commenti all'ordinamento e alle novità legislative (FATTI) e studi monografici (SAGGI).

Tutti i volumi pubblicati saranno sottoposti a un processo di peer review che ne attesta la validità scientifica.

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Table of Contents

Introduction

Marilisa D'Amico, Costanza Nardocci

Violence against women, or gender-based violence, manifests in increasingly diverse and rapidly evolving forms.

Legislative attempts to tackle all expressions of violence against women have yet to fully address the phenomenon in its entirety. However, recent years have seen significant progress in public awareness, legislation, and jurisprudence.

Since 1992, when the United Nations first recognized that violence against women constitutes a form of discrimination against women under the Convention on the Elimination of all forms of discrimination against women, major strides have been made.

Europe, and particularly the Council of Europe, has taken a leading role in combating gender-based violence by adopting the first treaty of its kind, entirely dedicated to building strategies for preventing, combating and punishing violence against women.

In 2011, however, the debate was strongly focused on intimate partner violence and domestic abuse. Such a trend is clearly traceable in the Istanbul Convention, which, not surprisingly, chooses to explicitly mention domestic violence in the title of the treaty.

More recently, in 2024, the European Union adopted its first Directive on violence against women. This marked a crucial step forward, aligning with the Council of Europe's approach while broadening the scope of protection.

As proof of the role of time as a key factor when human rights come to play, the EU Directive gives entrance to new forms of

violence, not listed under the Istanbul Convention. Notably, technology-facilitated forms of violence are now recognized as a serious violation of women's rights. This inclusion reflects a broader commitment to regulating emerging technologies in line with human rights principles. For instance, the nearly simultaneous adoption of the EU's first Regulation on Artificial Intelligence also mandates Member States to ensure that new technologies respect human rights, including women's rights.

Although Europe conquered a first spot – at least from a legislative point of view – in unraveling and regulating some of the newer and most unexpected forms of violence against women, such a pioneering approach does not cover all the additional and numerous areas that continue to be highly infiltrated by violence against women.

One particularly under-recognized area includes all forms of violence connected to women's reproductive rights.

Reproductive rights are among the most historically established of women's human rights. From the very start of discussions about the existence and conceptualization of women's rights, those related to reproduction have been considered fundamental. They underscore gender-based differences in human rights violations more than any other domain.

Notwithstanding their longstanding recognition, the law has somehow slowed its pace when it comes to identifying and sanctioning conducts that negatively endanger women's reproductive rights.

Thus, it comes as not much surprise that obstetric and gynecological violence were not originally acknowledged as forms of gender-based violence.

Even today, there is ongoing resistance to recognizing such violence as targeting women specifically because they are women.

Europe exemplifies this lack of recognition. Neither the Istanbul Convention nor the most recently adopted EU Directive make any mention of obstetric and gynecological (ob-gyn) violence.

Nonetheless, abortion rights – one of the most critical reproductive rights – remain hotly contested, not only overseas but also within several EU Member States. Meanwhile, EU Institutions have expressed

a desire to see abortion rights added to the EU Charter of Fundamental Rights.

This context reflects a broader legal *status quo* in which ob-gyn violence is still largely absent from the legal frameworks.

The conference held at the University of Milan on April 9th, 2024, sought to address this gap.

Enlarging the spectrum of legislative experiences, the conference gathered academics from various countries to comparative and supranational responses to ob-gyn violence.

The volume collects the papers presented during the venue and reflects the structure and aims of the conference.

It examines the Italian context, then compares it to the broader European scenario – considering both the EU and the Council of Europe perspectives – to highlight gaps and future challenges for a comprehensive strategy to protect all women from violence.

It then shifts its focus to Canada, exploring civil and criminal law implications of currently unregulated conduct that endangers women's reproductive rights.

Additionally, the book draws heavily on experiences from Latin America, the only region to have passed laws specifically addressing obstetric and gynecological violence. From Venezuela to Argentina to Mexico, Latin America stands at the forefront of the fight against ob-gyn violence.

Inspired by the progressive Belém do Parà Convention, the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, several chapters of the book offer an insight into the legislative and jurisprudential history of the Countries that, for now at least, sanction ob-gyn violence under the law.

Lastly, the book adopts a multidisciplinary and cross-sectoral approach, featuring the contributions from medical doctors about obstetric and gynecological violence. These chapters explore the often fine line between medical malpractice and violence against women, questioning whether an overly broad definition of ob-gyn violence is appropriate, particularly in cases where intent is lacking.

Ultimately, the book aims to position itself within the emerging, though still limited, literature on obstetric and gynecological violence, seeking to become a reference point for understanding and acknowledging such an often hidden yet deeply insidious form of violence against women in Europe and beyond.

Introductory Greetings

Francesca Zanasi

Dear students, dear Professors, dear all,

I am so pleased to be here with you today. I bring you the warm greeting of the Milan Bar Association, of its President Antonino La Lumia, and of the Foreign Affairs Committee (in short CRINT) which I preside.

It is a pleasure and an honour for me, as a lawyer, but also as a woman, to discuss issues that are essential aspects of the protection and safeguard of women's rights.

Resolution number 2306 of 2019 of the Council of Europe opens about obstetrical and gynaecological violence saying: "*Obstetrical and gynaecological violence is a form of violence that has long been hidden and is still too often ignored. In the privacy of a medical consultation or childbirth, women are victims of practices that are violent or that can be perceived as such*".

According to the European Union Agency for Fundamental Rights, one in three women in Europe is a victim of gender-based violence, as is the case of obstetrical and gynaecological violence suffered by women and girls, irrespective of income or country where they live.

As some of you know, for many years I've had the privilege of working in family counselling centres in the city of Milan, I've seen what violence can do to women, and I have always fought to protect them as a lawyer.

Medical violence, and in particular obstetrical and gynaecological violence, has remained hidden for too long, it is difficult to detect, and even more difficult to combat.

In the doctor's office, or during childbirth, each person should feel safe, which is why they are often defenceless. It is therefore difficult to ascertain bad and disrespectful behaviour, and to implement tools to defend oneself.

Therefore, it is upmost important to stimulate and contribute to the medical debate, but also to the legislative, social and political discussion, to really proactively improve women's life and civil society.

For all these reasons, I thank Università Statale di Milano for organising this conference, professors Marilisa D'Amico and professor Costanza Nardocci for their constant and tireless commitment to human and women's rights, always with and international outlook, and all the speakers for being here today. I hope that the increasing awareness on these issues can change all of us here today, and also give the impetus for real change within society.

Thank you again on behalf of the Milan Bar Association and its Foreign Affairs Committee.

Part One
Obstetrical, Gynecological Violence, and the Law

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Understanding Obstetric and Gynaecological Violence: Law Perspectives and Experiences from Québec, Canada*

Audrey Ferron-Parayre

1. Introduction

Obstetric and gynaecological violence (henceforth referred to as 'OGV') can be defined as any gesture, word or omission that occurs within the context of obstetric or gynaecological care and is perceived as disrespectful, degrading, abusive, discriminatory or violent by the individuals who are subjected to it. The concept of OGV has its origins in South America[1], where it emerged as part of the broader movement

* This text reports on the work undertaken as part of the JusticeVOG research programme, funded by the Canadian Institutes of Health Research (CIHR), the Social Sciences and Humanities Research Council of Canada (SSHRC), and the ministry of Women and Gender Equality of Canada.

1. See for instance Ximena Briceño Morales, Laura Victoria Enciso Chaves, Carlos Enrique Yepes Delgado, *Neither Medicine Nor Health Care Staff Members Are Violent By Nature: Obstetric Violence From an Interactionist Perspective*, in *Qualitative Health Research*, (2018) 28:8, 1308; *Law on the Right of Women to a Life Free of Violence*, Official Gazette of Venezuela, art. 15(13), translated by Rogelio Pérez D'Gregorio, *Obstetric violence: a new legal term introduced in Venezuela*, in *Int J Gynaecol Obstet*, (2010) 111:3, 201.

for the humanisation of childbirth[2]. Rooted in the reality of the over-medicalisation of childbirth and a perceived loss of control and agency for those who give birth, this movement sought to shift the focus back to the fact that childbirth is first and foremost a natural physiological process, rather than a pathology. Furthermore, it highlighted the potential harms of medical interventions on the health of mothers and babies.

In North America[3] and Europe, the advent of the OGV concept was concomitant with the emergence of a social movement that sought to denounce sexual assault in the 2010s. In the aftermath of the #metoo movement, social media platforms witnessed the emergence of new keywords, including in France[4] *#balancetonutérus* [denounce your womb] and *#balancetongynéco* [denounce your gynaecologist]. Just as certain sexual practices were previously regarded as ordinary and accepted are now subjected to scrutiny, criticism, and condemnation for their dehumanising impact on those who are subjected to them,

2. For instance, see Rogelio Pérez D'Gregorio, *Obstetric violence: a new legal term introduced in Venezuela*, in *Int J Gynaecol Obstet*, (2010) 111:3, 201; Simone Grilo Diniz *et al.*, *Abuse and disrespect in childbirth care as a public health issue in Brazil: origins, definitions, impacts on maternal health, and proposals for its prevention*, in *Journal of Human Growth and Development*, (2015) 25:3, 377.

3. See for instance Maria TR Borges, *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, in *Duke Law Journal* (2018) 67, 827; Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, (2016) 24:47, 56; Elizabeth Kukura, *Obstetric Violence*, in *Geo LJ*, (2018) 106:3, 721; Saraswathi Vedam *et al.*, *The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States*, in *Reproductive Health* (2019), 16, 77.

4. See for instance Mélanie Déchalotte, *Le livre noir de la gynécologie. Maltraitances gynécologiques et obstétricales: libérer la parole des femmes*, Éditions First, 2017; Diane Roman, *Les violences obstétricales, une question politique aux enjeux juridiques*, in *Revue de droit sanitaire et social*, (2017) 867; Haut conseil à l'égalité entre les hommes et les femmes, *Les actes sexistes durant le suivi gynécologique et obstétrical. Des remarques aux violences, la nécessité de reconnaître, prévenir et condamner le sexisme*, Haut conseil à l'égalité entre les hommes et les femmes, 2018): online: *https://www.haut-conseil-egalite.gouv.fr/sante-droits-sexuels-et-reproductifs/actualites/article/actes-sexistes-durant-le-suivi-gynecologique-et-obstetrical-reconnaitre-et.*

some practices and language used in the context of obstetric and gynaecological care are now subject to the same critical scrutiny. The legitimacy of these practices is increasingly being challenged, and their acceptance is waning among an expanding segment of the population.

In Québec just as in South America, perinatal rights movements were among the first to acknowledge, condemn and mobilise the public and stakeholders' awareness on the issues raised by OGV[5]. Their work and commitment to these issues led to a growing number of studies and research aiming at defining, understanding and preventing the occurrence of OGV in clinical practice[6]. In 2023, we started a research program aiming at exploring how law can be used as a tool to both *prevent* occurrences of OGV and give *access to justice* to those who suffered it[7]. In our projects, we chose to broadly define obstetric and gynaecological violence as various forms of abuse, disrespect and maltreatment perpetrated in the context of obstetric and gynaecological care. While the vast majority of these forms of violence affect cisgender women, they are likely to occur to anyone who seeks gynaecological care or who may be pregnant, whether they are female or not and whether they identify as a woman or not[8].

5. See, for instance, *Regroupement Naissances Respectées*, *https://www.naissancesrespectees.org/*.

6. See for instance Sylvie Lévesque *et al.*, *La violence obstétricale dans les soins de santé : une analyse conceptuelle*, in *Recherches féministes*, (2018) 31:1, 219; Marianne Labrecque, *Expériences négatives d'accouchements décrites par des femmes ayant accouché en milieux hospitaliers : les liens avec le concept des violences obstétricales* (M.Sc. thesis, Université de Montréal, 2018); Marie-Pier Landry, *Expériences de violence obstétricale en milieu hospitalier québécois : une analyse féministe intersectionnelle* (M.Sc. thesis, Université Laval, 2019).

7. *https://www.justicevog.ca/* [in French only]. This research programme is based on a partnership with community associations, institutional partners in the legal and healthcare fields, and associations of healthcare professionals. The co-researchers Sylvie Lévesque, Marie-Josée Bédard, Emmanuelle Bernheim, Dominique Bernier, Marième Lacroix and Catherine Régis come from a variety of disciplines (law, sexology, public health, medicine, ethics and sociology), enabling an interdisciplinary research approach.

8. Therefore, I will use the words 'women', 'people' or 'individuals' interchangeably throughout this text. The choice of these words is in no way

In this paper, I aim to present an overview of the data, issues and hypotheses that have informed our research activities since its inception. Although our research is geographically – and legally – situated in the province of Québec, Canada[9], it is informed by studies from Europe, South America, Australia and the United States; the data sources are diverse and varied. We also mobilised a *reproductive justice* framework throughout our research projects. Reproductive justice is a conceptual framework that examines the experience of reproduction based on three key principles: the right not to have children, the right to have children, and the right to raise children in a dignified and safe environment. It also acknowledges the complete sexual autonomy and gender freedom of every individual[10]. Obstetric and gynaecological violence, insofar as it encompasses gynaecological care, fertility care and obstetric care, is intimately linked to these principles. Originating in the United Stated from groups of black and racialised women, reproductive justice fuses the concepts of reproductive rights and social justice[11]. The mobilisation of reproductive justice facilitates a

intended to make anyone who experienced OGV as part of their healthcare invisible.

9. It could be useful, for some readers, to have more context on the healthcare system in Québec, Canada. Canada is a federation comprising ten provinces, with Québec being one of them. From a Canadian constitutional perspective, healthcare services' organisation and management are provincial competencies. Nevertheless, healthcare system all over Canada is based on a universal and free access to hospital and medically required care. The core principles of this universal healthcare system are set out in the *Canada Health Act*, R.C.S., 1985, c. C-6, a legislative instrument whose primary purpose is to provide rules for provinces to obtain Canadian Parliament's financial contribution regarding health services. Therefore, to benefit the financial contribution from the Canadian government, the provinces are required to maintain a healthcare system that is publicly administered, with a one hundred percent cover for all insured health services designated in the *Canada Health Act*, free from extra-billing and user charge practices.

10. Caroline Jacquet, Geneviève Pagé, Magaly Pirotte, *Continuités et ruptures dans le mouvement féministe québécois francophone pour des droits sexuels et reproductifs*, in *Nouvelles Questions Féministes* (2017) 36, 16.

11. Loretta J. Ross, Rickie Solinger, *Reproductive Justice. An Introduction*, University of California Press, 2017.

critical examination of the effectiveness of law as a preventing and restoring tool.

Throughout the following pages, I will outline the fundamental concepts that underpin the phenomenon of obstetric and gynaecological violence, namely human rights, systemic and gender-based violence (II). I will then give an overview of the quantitative and qualitative data that support the available evidence on occurrence and consequences of OGV, with a particular interest for occidental healthcare systems (III). This will lead me to outline the work we are conducting on law as a tool of prevention and reparation for people suffering OGV (IV). Finally, concluding remarks will allow me to take a critical look at the assumptions underlying our research on OGV and the law, and to briefly address some preliminary findings that emerge from our work (V).

2. Obstetric and gynaecological violence: a proof of concept

The conceptualisation of obstetric and gynaecological violence is a challenging endeavour, due to the broad spectrum of behaviours and practices it encompasses, many of which are deeply entrenched in routine obstetric-gynaecological care. While these behaviours and practices have always existed, they have only recently been designated as 'violent', giving rise to contentious debates[12]. Furthermore, no clear

12. Nevertheless, there seems to be some consensus on the use of the term 'violence'. As an illustration, PubMed database was searched on 17 December 2024, using search terms in titles for the past five years. Combinations using disrespect, abuse and mistreatment yielded a total of 63 results, with many being duplicates ((childbirth* AND/OR pregnan* AND/OR labour*) AND abuse*[Title] = 26 results; (childbirth* AND/OR pregnan* AND/OR labour*) AND mistreatment*[Title] = 18 results; (childbirth* AND/OR pregnan* AND/OR labour*) AND disrespect*[Title] = 19 results). In contrast, the search "obstetric* violence* [Title]" generated 126 different papers. For different perspectives on the naming of "violence" in obstetric and gynecological care, see Rachelle Chadwick, *The Dangers of Minimizing Obstetric Violence*, in *Violence Against Women*, (2023) 29:9, 1899; Lappeman and Swartz, *How gentle must violence against women be in order not to be violent? Rethinking the word*

definition emerges from the literature on obstetric – and gynaecological[13] – violence.

A study by the Policy Department for Citizens' Rights and Constitutional Affairs of the European Parliament notes that OGV "encompasses multiple forms of harmful practices perpetrated during obstetric and gynaecological care. While obstetric violence may be suffered during pregnancy, childbirth and post-partum, women might experience gynaecological violence during gynaecological consultations throughout their lives"[14] . The World Health Organization (WHO), although not using explicitly the term 'violence', identifies abuse, disrespect, and mistreatment in childbirth caused by healthcare professionals as violations of women's dignity[15]. In 2019, the United Nations' Special Rapporteur on violence against women submitted a report on mistreatment and violence against women in reproductive health services, focusing on childbirth and obstetric violence. The

'violence' in obstetric settings", in *Violence Against Women*, (2021) 27:8, 987; Sylvie Lévesque, Audrey Ferron-Parayre, *To Use or Not to Use the Term 'Obstetric Violence': Commentary on the Article by Swartz and Lappeman*, in *Violence Against Women*, (2021) 27:8, 1009; Frank A. Chervenak *et al.*, *Obstetric violence is a misnomer*, in *AJOG*, (2024) S1138.

13. Despite the paucity of literature addressing the specific nature of gynaecological violence, there is an increasing interest in the subject. See for instance Manuel Cardenas-Castro, Stella Salinero-Rates, *Loss of autonomy, legitimization of violence, transgression of intimacy, and fear of abuse: A thematic analysis of stories of gynecological violence and its consequences*, in *Feminism & Psychology*, (2024) 34:3, 403; Leslie Fonquerne, 'C'est pas la pilule qui ouvre la porte du frigo!' *Violences médicales et gynécologiques en consultation de contraception*, in *Santé publique*, (2021) 33:5, 663. On fertility care and the medical violence experienced by women in the specific context of these treatments, listen to the *The New York Times* and *Serial Productions*' podcast "The Retrievals", by Susan Burton, Laura Starecheski, online: *https://the-retrievals.simplecast.com/*.

14. *Obstetric and gynaecological violence in the EU – Prevalence, legal frameworks and educational guidelines for prevention and elimination*, study requested by the European Parliament's Committee on Women's Rights and Gender Equality (Policy Department for Citizens' Rights and Constitutional Affairs of the European Parliament, Brussels, European Union, 2024, 13).

15. *Statement on the Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth*, World Health Organization, Geneva, Switzerland, 2015.

Special Rapporteur chose to use the term 'obstetric violence' "when referring to violence experienced by women during facility-based childbirth"[16]. Despite differences in the definition of OGV, three elements can be identified at the core of any conceptualisation of this phenomenon: it constitutes infringements on basic human rights, it is a systemic violence and a form of gender-based violence.

Obstetric and gynaecological violence, by its very nature, infringes fundamental human rights[17]. The infringement of rights can be categorised into various forms, including the rights to integrity and autonomy, which underlie the right to consent to and refuse care, the rights to dignity, to privacy, the right to be accompanied by a person of one's choice during care, and to obtain another medical opinion, all of the these rights being enshrined in a variety of legislative acts within the province of Québec: "No one may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent"[18]; "The privacy of a person may not be invaded without the consent of the person or without the invasion being authorized by the law"[19]; "Every user is entitled to participate in any decision affecting his state of health or welfare"[20].

The aforementioned rights are broadly consistent with the fundamental rights recognised to all individuals, as well as, more

16. United Nations General Assembly, *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 and Obstetric Violence*, UN Doc A/74/137, United Nations General Assembly, New York, 2019, 6.

17. See for instance Caitlin R Williams, Benamin Mason Meier, *Ending the abuse: the human rights implications of obstetric violence and the promise of rights-based policy to realise respectful maternity care*, in *Sexual and Reproductive Health Matter*, (2019) 27:1, 9.

18. *Civil Code of Québec*, CQLR c CCQ-1991, s. 11 al. 1. See also *Charter of Human Rights and Freedoms*, CQLR c C-12, s. 1 (right to life, personal security, inviolability and freedom), 4 (right to the safeguard of one's dignity) and 5 (right to respect of one's private life).

19. *Civil Code of Québec*, CQLR c CCQ-1991, s. 35 al. 1.

20. *Act respecting health services and social services*, CQLR c S-4.2, s. 10 al. 1.

specifically, with the rights recognised to women in terms of health: "Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care"[21]. Obstetric and gynaecological violence constitutes an infringement of these rights, since it includes situations where consent to care is not obtained, refusal of care is not respected, disclosure of the information necessary for informed consent is incomplete or even absent, care is provided without respect for the patient's privacy, or yet, discriminatory words are spoken[22].

As demonstrated in the extant literature, the right of women to autonomy, and their capacity to provide genuine and effective informed consent or refusal to the care they are offered, are pivotal to the occurrence of OGV[23]. A conceptual analysis of obstetrical violence in healthcare in the province of Québec context has highlighted certain attributes of this violence, the main one being that informed consent is undermined[24]. The extant literature suggests that the implementation of the right to informed consent is generally weak in medicine[25], more so in the specific context of gynaecological care and childbirth[26]. Recent

21. World Health Organization, *Statement on the Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth*, World Health Organization, Geneva, Switzerland, 2015.

22. Meghan A. Bohren *et al.*, *The Mistreatment of Women during Childbirth in Helat Facilities Globally: A Mixed-Methods Systematic Review*, in *PLOS Med*, (2015) 12 e1001847; Elizabeth Prochaska, *Human Rights Law and Challenging Dehumanisation in Childbirth, A Practitioner's Perspective*, in Camilla Pickles, Jonathan Herring (eds.), *Childbirth, Vulnerability and Law. Exploring Issues of Violence and Control*, Routledge, 2020, 132.

23. Maria TR Borges, *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, in *Duke Law Journal* (2018), 67, 827; Elizabeth Kukura, *Obstetric Violence*, in *Geo LJ*, (2018) 106:3, 721; Lisa Forsberg, *Childbirth, consent, and information about options and risks*, in Camilla Pickles, Jonathan Herring (eds.), *Childbirth, Vulnerability and Law. Exploring Issues of Violence and Control*, Routledge, 2020, 161.

24. Sylvie Lévesque *et al.*, *La violence obstétricale dans les soins de santé : une analyse conceptuelle*, in *Recherches féministes*, (2018) 31:1, 219.

25. Audrey Ferron-Parayre, *Donner un consentement éclairé aux soins : réalité ou fiction?*, Éditions Yvon Blais, 2021.

26. Louise Langevin, *Le droit à l'autonomie procréative des femmes : entre*

studies on pregnancy monitoring and consent to care have demonstrated that, despite explicit obligations to provide information and obtain consent for all care provided during pregnancy, women have reported a lack of information or, conversely, being overwhelmed by information they do not comprehend, or having to acquiesce to treatment that has already been decided by the healthcare professional[27]. Nevertheless, this does not preclude the occurrence of OGV even in circumstances where consent has been provided, for instance, in situations where the presence of an accompanying individual is declined. It is further important to note that these rights, already fragile, are even more so in periods of social or health upheaval, such as the ongoing global pandemic of the SARS-CoV-2[28].

Medicine, and obstetrics and gynaecology in particular, has a history of knowledge development and epistemological posture that has resulted, to some extent, in the production of a patriarchal and sexist system[29]. Furthermore, patient-carer relationships are frequently

liberté et contrainte [Women's right to reproductive autonomy: between freedom and constraint], Éditions Yvon Blais, 2020; Marlène Cadorette, *Le consentement libre et éclairé de la parturiente en droit québécois : l'accouchement comme contexte d'évitement du respect de l'autonomie*, PhD thesis, Québec, Université Laval, 2006.

27. Rachel G. Logan *et al.*, *Coercion and Non-Consentig During Birth and Newborn Care in the United States*, in *Birth* (2022), 49:4, 749; Jacqueline A. Nicholls *et al.*, *Consent in pregnancy: A qualitative study of the views and experiences of women and their healthcare professionals*, in *European Journal of Obstetrics & Gynecology and Reproductive Biology* (2019) 238, 132; Jacqueline A. Nicholls *et al.*, *Consent in pregnancy - an observational study of ante-natal care in the context of Montgomery: all about risk?*, in *BMC Pregnancy Childbirth* (2021), 102, 21; Tanya Djanogly *et al.*, *Choice in episiotomy – fact or fantasy: a qualitative study of women's experiences of the consent process*, in *BMC Pregnancy Childbirth* (2022), 22, 139; Laxsini Murugesu *et al.*, *Women's Participation in Decision-Making in Maternity Care: A Qualitative Exploration of Clients' Health Literacy Skills and Needs for Support*, in *International Journal of Environmental Research and Public Health* (2021), 18, 1130.

28. Audrey Ferron-Parayre, *Les droits des femmes en matière de santé reproductive : les effets de la pandémie de Covid-19*, in *Les Cahiers de Droit* (2022), 63, 43.

29. See for instance Elinor Cleghorn, *Unwell Women – Misdiagnosis and Myth in a Man-Made World*, Penguin Random House, 2021; Dana-Ain Davis, *Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing*, in *Medical*

characterised by imbalanced power dynamics, wherein carers, in their professional capacity and with scientific knowledge, are regarded as the authorities on the subject, while patients are often seen as vulnerable and uninformed[30]. In this context, OGV can occur as the result of systemic factors that relate to culture, education and socialisation. Therefore, the intentionality of the violent or unrespectful nature of the gestures has never been retained as a definitive element of OGV in several South American laws, nor by the experts and researchers who have studied the issue[31].

Moreover, the public healthcare system in Québec, as in the rest of Canada, is subject to considerable performance and efficiency pressures. This has resulted in a reduction of the time allocated for each medical appointment, leading to a depersonalisation of care, rushed services and exhaustion among healthcare professionals[32]. The quality of care provided is thus impacted by those factors. It is

Anthropology (2018), 38:7, 1; Deirdre Cooper Owens, *Medical Bondage: Race, Gender and the Origins of American Gynecology* (Athens, University Press of Georgia, 2017); Andrée Rivard, *Histoire de l'accouchement dans un Québec moderne*, Les éditions du remue-ménage, 2014.

30. Felicity Goodyear-Smith, Stephen Buetow, *Power Issues in the Doctor-Patient Relationship*, in *Health Care Analysis* (2001), 9, 449; Raymonde Gagnon, *La grossesse et l'accouchement à l'ère de la biotechnologie : l'expérience de femmes au Québec*, PhD thesis, Université de Montréal, 2017; Stella Villarmea, *When a Uterus Enters the Room, Reason Goes out the Window*, in Camilla Pickles, Jonathen Herring (eds.), *Women's Birthing Bodies and the Law – Unauthorized Intimate Examinations, Power and Vulnerability*, Hart Publishing, 2020, 63.

31. See Camilla Pickles, *'Everything is Obstetric Violence Now': Identifying the Violence in 'Obstetric Violence' to Strengthen Socio-legal Reform Efforts*, in *Oxford Journal of Legal Studies* (2024), 44:3, 616; Caitlin R. Williams *et al.*, *Obstetric violence: a Latin American legal response to mistreatment during childbirth*, in *BJOG* (2018), 125, 1208, Louise Langevin, *Le droit à l'autonomie procréative des femmes : entre liberté et contrainte*, Éditions Yvon Blais, 2020; Diane Roman, *Les violences obstétricales, une question politique aux enjeux juridiques*, in *Revue de droit sanitaire et social* (2017), 867.

32. Josée Grenier, Mélanie Bourque, *Les Services sociaux à l'ère managériale*, Presses de l'Université Laval, 2019; National Academy of Medicine, *Taking action against clinician burnout: A systems approach to professional well-being*, Washington, The National Academies Press, 2019.

therefore possible to interpret OGV as a form of structural violence, created and maintained by social, cultural, political and economic systems that engender and trivialise certain gestures, behaviours and omissions causing harm to patients[33]. Hence, obstetric and gynaecological violence is not merely a matter of interpersonal context or professional misconduct. Rather, it is a combination of systemic factors that interact to create and maintain conditions conducive to the incidence and maintenance of these preventable practices. As researchers from Chile, Portugal, Spain, Italy, United Kingdom, United States and Denmark have summarised so well, "[t]his reinforces the need for a broader analysis, centred in the cultural and social dimensions embedded in the phenomenon of obstetric violence, which can allow a shift from the limited focus on victims (women) and victimisers (health professionals), to the acknowledgement of the ubiquitous socialisation of men and women into naturalised, and thus invisible, forms of violence and power dynamics between groups"[34]. This leads me to a consideration of the gender dimension of obstetric and gynaecological violence.

Gender-based violence is a concept that "recognises that violence occurs within the context of women's and girl's subordinate status in society, and serves to maintain this unequal balance of power"[35]. Gender-based violence often takes roots in gender biases and stereotypes that construct social norms where women's bodies are dehumanized and objectified, being seen more as vessels for specific purposes (i.e. bearing children, men's pleasure, domestic tasks, etc.) than independent, autonomous humans. In medicine, sexism and patriarchy influence the way women are diagnosed, treated, listened to, believed or dismissed[36].

33. Alison Rutherford *et al.*, *Violence: a glossary*, in *J Epidemiol Community Health* (2007), 61, 676.

34. Michelle Sadler *et al.*, *Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence*, in *Reproductive Health Matters* (2016), 24, 47, 51.

35. Alison Rutherford *et al.*, *Violence: a glossary*, in *J Epidemiol Community Health* (2007), 61, 676; Charlotte Watts, Cathy Zimmerman, *Violence against women: global scope and magnitude*, in *The Lancet* (2002), 359:9313 P1232.

36. For a general societal approach, see Caroline Criado Perez, *Invisible Women. Data Bias in a World Designed for Men*, Abrams Press, 2021. For an

From an obstetrics and gynaecological perspective, gender biases "arise from religious, social and cultural beliefs and ideas about sexuality, pregnancy and motherhood"[37]. These stereotypes enforce, for instance, the idea that women are "docile, caring, nurturing and soft"[38], hence influencing the perception of the 'good' female patient.

Gender-based violence also relates to the social and cultural practice of silencing the voices of women questioning the 'normality' of experiencing pain during gynaecological care, or the traumatic experiences they endured during labour: "but you have a healthy baby, why complaining?"[39]. This also entails to the stereotype of the self-sacrificing mother, the 'good' mother that will inevitably do or accept any care that is deemed to be in the baby's interest, according to the treating healthcare professionals[40].

analysis more specific to medicine and healthcare, see Elinor Cleghorn, *Unwell Women. Misdiagnosis and Myth in a Man-Made World*, Penguin Random House LLC, 2021. See also Katherine Hay *et al.*, *Disrupting gender norms in health systems: making the case for change*, in *The Lancet* (2019), 393, 2535.

37. Christina Zampas, *Human Rights and Gender Stereotypes in Childbirth*, in Camilla Pickles, Jonathen Herring (eds.), *Women's Birthing Bodies and the Law – Unauthorized Intimate Examinations, Power and Vulnerability*, Hart Publishing, 2020, 79, 81.

38. Catarina Barat, Vania Simoes, Francisca Soromenho, *Obstetric Violence: A Form of Gender-Based Violence*, in Stacey Banwell *et al.* (eds.), *The Emerald International Handbook of Feminist Perspectives on Women's Acts of Violence*, Emerald Publishing Limited, 2023, 203, 209.

39. Rachelle Chadwick, *Practices of silencing: birth, marginality and epistemic violence*, in Camilla Pickles, Jonathan Herring (eds.), *Childbirth, Vulnerability and Law. Exploring Issues of Violence and Control*, Routledge, 2020, 30; Jonathan Herring, *Identifying the wrong in obstetric violence: lessons from domestic abuse*, in Camilla Pickles, Jonathan Herring (eds.), *Childbirth, Vulnerability and Law. Exploring Issues of Violence and Control*, 2020, 67; Aurore Koechlin, *La norme gynécologique. Ce que la médecine fait au corps des femmes*, Éditions Amsterdam, 2022.

40. Nicole Hill, *Understanding Obstetric Violence as Violence against Mothers through the Lens of Matricentric Feminism*, in *Journal of the Motherhood Initiative* (2019), 10:1-2, 233; Rotem Kahalon, Verena Klein, *Unmasking the Role of Dehumanization in Obstetric Violence*, in *Psychology of Violence* (2025) 15:1, 21.

Finally, it has been hypothesised that the feminisation of the medical profession would result in a concomitant decline in gender-based violence within obstetrics and gynaecology care. Unfortunately, research pertaining to the process of socialisation to one's profession illustrates that professional training tends to homogenize attitudes of trainees, thus erasing potential differences between genders' approaches to the profession[41]. This has been demonstrated in medicine in general, and in obstetrics-gynaecology in particular[42], making gender-based biases and violence still a reality, despite the feminisation of the profession.

3. Prevalence and consequences of obstetric and gynaecological violence: a look at the evidence

Obstetric and gynaecological violence too often is, as I highlighted in the previous part, a form of violence that is framed as "natural, expected and accepted" as part of a woman's life[43]. However, the last decade

41. Camilla Pickles, Jonathan Herring, *Introduction*, in Camilla Pickles, Jonathen Herring (eds.), *Women's Birthing Bodies and the Law – Unauthorized Intimate Examinations, Power and Vulnerability*, Hart Publishing, 2020, 1, 10; Ruth E. Zambrana, Wendy Mogel, Susan C.M. Scrimshaw, *Gender and Level of Training Differences in Obstetricians' Attitudes Towards Patients in Childbirth*, in *Women & Health* (1987), 12:1, 5.

42. Sirpa Mattila-Lindy *et al.*, *Physicians' Gender and Clinical Opinions of Reproductive Health Matters*, in *Women & Health* (1998), 26:3, 15; Michael C. Klein *et al.*, *Attitudes of the New Generation of Canadian Obstetricians: How Do They Differ from Their Predecessors?*, in *Birth* (2011), 38, 129; Peter A. Ubel *et al.*, *Don't Ask, Don't Tell: A Change in Medical Students Attitudes after Obstetrics/Gynecology Clerkships toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient*, in *American Journal of Obstetrics and Gynecology* (2003), 118, 575; Catarina Barat, Vania Simoes, Francisca Soromenho, *Obstetric Violence: A Form of Gender-Based Violence*, in Stacey Banwell *et al.* (eds.), *The Emerald International Handbook of Feminist Perspectives on Women's Acts of Violence*, Emerald Publishing Limited, 2023, 203, 211.

43. Michelle Sadler *et al.*, *Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence*, in *Reproductive Health Matters* (2016), 24, 47, 52. See also Sara Cohen Shabot, *Why 'normal' feels so bad: Violence and*

of naming, defining and denouncing OGV has allowed a growing number of scientists and research projects to delve into the occurrence of this form of violence in reproductive, obstetric and gynaecological healthcare. In the following paragraphs, I will focus on data from high-income countries in order to make them more comparable to the reality in Canada and Québec[44]. This data illustrates that OGV is far from anecdotal: it is widespread and affects women in every aspect of their lives, far beyond their sexual and reproductive health.

In the United States, a study reported that 17.3% of participants had experienced at least one incident of violence described as maltreatment during their pregnancy[45]. Data from the same study also show that 30.6% of participants felt pressured to consent to care at some point during their delivery; 40.7% of them never gave their consent to at least one care procedure performed during their delivery (e.g. 23.1% of participants did not consent to the puncture of the amniotic sac and 26% of them never consented to continuous fetal monitoring)[46].

In France, the report from the *Haut conseil à l'*égalité *entre les femmes et les hommes* [High Council for Equality between Women and Men] identifies a 50% prevalence of non-consensual episiotomies, while 6% of women say they are dissatisfied with their pregnancy monitoring or childbirth – an absolute number of 50,000 women in 2016 – and 3.4% of ethical complaints to the French Medical Association in 2016 concerned sexual assault or rape by doctors[47]. A prospective study in

vaginal examinations during labour – A (feminist) phenomenology, in *Feminist Theory* (2021), 22:3, 443.

44. But far from being spared, women in low and middle-income countries face just as many, if not more obstetric and gynaecological violence, often with more severe consequences. For a global analysis, see Suellen Miller *et al.*, *Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide*, in *The Lancet* (2016), 388:10056, 2176.

45. Saraswathi Vedam *et al.*, *The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States*, in *Reproductive Health* (2019), 16, 77.

46. Rachel G. Logan *et al.*, *Coercion and Non-Consentig During Birth and Newborn Care in the United States*, in *Birth* (2022), 49:4 749.

47. Haut conseil à l'égalité entre les hommes et les femmes, *Les actes sexistes*

maternity units in Burgundy, France, reported an incidence of obstetric violence of 44% and highlighted that the majority of OGV experienced by women was related to the process of consenting to care: failure to obtain or respect consent (21.5%) and inadequate information for at least one procedure (14.4%)[48]. In Switzerland, a national survey of women having given birth in the past 12 months (n=6054) found that 26.7% of respondents had experienced informal coercion during labour and childbirth[49].

A national mixed-method study looked at Australian women's experiences of childbirth in the previous five years[50]. More than one woman out of ten (11.6%) answered "yes" or "maybe" to the question: "Do you think you experienced obstetric violence (dehumanized treatment or abuse by health professionals toward the body or reproductive process of women)?", with this percentage varying from 33% in New South Wales to 2.93% in Tasmania[51]. Among the experiences of obstetric violence that were mostly reported by respondents, the perceptions were of being dehumanized (58%), being violated (26%) and feeling powerless (16%)[52].

In the Netherlands, a national survey questioned 12,239 women who gave birth in the previous five years[53]. Near 40% (39.8%) of

durant le suivi gynécologique et obstétrical. Des remarques aux violences, la nécessité de reconnaître, prévenir et condamner le sexisme, Haut conseil à l'égalité entre les hommes et les femmes, 2018, online: *https://www.haut-conseil-egalite.gouv.fr/sante-droits-sexuels-et-reproductifs/actualites/article/actes-sexistes-durant-le-suivi-gynecologique-et-obstetrical-reconnaitre-et.*

48. Salomé Malet *et al.*, *Violence au bloc obstétrical : une enquête prospective multicentrique auprès des femmes dans les maternités de Bourgogne*, in *Gynécologie Obstétrique Fertilité & Sénologie* (2020), 48, 790.

49. Stephan Oelhafen *et al.*, *Informal coercion during childbirth: risk factors and prevalence estimates from a nationwide survey of women in Switzerland*, in *BMC Pregnancy Childbirth* (2021), 21:369: *https://doi.org/10.1186/s12884-021-03826-1.*

50. Hazel Keedle, Warren Keedle, Hannah G. Dahlen, *Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years*, in *Violence Against Women* (2022), 30:9, 2320.

51. Ivi, 2320, 2327.

52. Ivi, 2320, 2328.

53. Marit S.G. van der Pijl *et al.*, *Disrespect and abuse during labour and birth*

respondents reported lack of choices, for instance, being unable to choose the birthing position (25.3%). Three percent reported that an intervention was continued even after specifically asking to stop; almost all women who experienced this type of violence (97%) found it upsetting. Lack of communication and lack of support were reported respectively by 29.9% and 21.3% of respondents, while 'harsh or rough treatment/physical violence' was experienced by one out of five women (21.1%)[54]. Overall, 20% of respondents rated their experience as being negative (11.9%) or very negative/traumatic (9%). In Spain, a high occurrence rate of obstetric violence (67.6%) was reported by respondents (n=899) to a cross-sectional observational study in 2019, with a 54.5% prevalence of physical violence, 36.7% of psycho-affective violence and 25.1% of verbal violence[55].

Beyond prevalence or occurring OGV episodes, available data provide an overview of the ways in which this form of violence manifests itself, particularly highlighting the vulnerabilities heightened by intersectionality. The study previously discussed from the United States found that people most likely to experience OGV presented one or more of the following characteristics: nulliparous, aged 17-25 years, low socioeconomic status, history of substance use, violent marital relationship, high-risk pregnancy, race, and disagreement with caregiver about preferred choice of treatment[56]. In Québec, Indigenous women are particularly likely to report experiences of OGV in hospitals, including forced sterilisation[57]. In both Québec and Canada,

amongst 12,239 women in the Netherlands: a national survey, in *Reproductive Health* (2022), 19:160: *https://doi.org/10.1186/s12978-022-01460-4*.

54. Ivi: *https://doi.org/10.1186/s12978-022-01460-4, 6.*

55. Juan Miguel Martinez-Galiano *et al.*, *The magnitude of the problem of obstetric violence and its associated factors: a cross-sectional study*, in *Women and Birth* (2021), 34, e526, e528.

56. Saraswathi Vedam *et al.*, *The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States*, in *Reproductive Health* (2019), 16, 77.

57. Regroupement Naissance-Renaissance *et al.*, *Avis sur les mauvais traitements et les violences envers les femmes dans les services de soins de santé reproductive aux attention particulière sur l'accouchement*, report presented to the United Nations Special Rapporteur on Violence Against Women (Montréal, may 2019), online:

transgender men report particular difficulties in access to and quality of reproductive health care[58]; discrimination on the basis of disability has also been reported in relation to positive screening tests for Down syndrome[59]. In both Canada and United States, discriminatory care is experienced by black people, whose pain is, for instance taken less seriously than that of white people[60]. In Iceland, a study highlighted that disabled people also face significant prejudice and stigma about their parenting abilities when it comes to fertility care, pregnancy monitoring and childbirth[61]. Although all women and individuals requiring obstetric-gynaecological care are susceptible to experiencing

https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/Regroupement%20Naissance-Renaissance%20Canada.pdf; Suzie Basile, Patricia Bouchard, *Consentement libre et éclairé et stérilisations imposées de femmes des Premières Nations et Inuit au Québec. Rapport préliminaire*, Commission de la santé et des services sociaux des premières nations du Québec et du Labrador, 2022; Enquête nationale sur les femmes et les filles autochtones disparues et assassinées, *Réclamer notre pouvoir et notre place : le rapport final de l'Enquête nationale sur les femmes et les filles autochtones disparues et assassinées, volumes 1a et 1b*, 2019, online: *https://www.mmiwg-ffada.ca/fr/final-report/*.

58. Charlie E. Davis *et al.*, *'We're all in an abusive relationship with the health-care system': Collective memories of transgender health care*, *The Canadian Journal of Human Sexuality* (2021), 30, 183; Mylène Shankland, *Penser la reconnaissance sociale intersubjective à travers les expériences de grossesse chez les hommes trans au Québec : analyse (trans)féministe et honnethienne*, M.Sc. thesis, Université du Québec à Montréal - UQAM, 2020.

59. Cynthia Henriksen, *Les tests prénataux : enjeux éthiques et politiques liés à la poursuite de grossesse après détection d'aneuploïdie foetale*, M.Sc. thesis, Université de Montréal, 2020.

60. Katherine Novello-Vautour, *Discriminer le miracle de la vie : la violence obstétricale chez les personnes noires et autochtones dans les institutions de santé au Canada* [Discriminating against the miracle of life: obstetrical violence against black and aboriginal people in Canadian health care institutions], M.Sc. thesis, University of Ottawa, 2021; Christine M Labuski, *A black and white issue? Learning to see the intersectional and racialized dimensions of gynecological pain*, in *Soc Theory Health* (2017), 15, 160.

61. James Gordon Rice, Helga Baldvins Bjargardóttir, Hanna Björg Sigurjónsdóttir, *Child Protection, Disability and Obstetric Violence: Three Case Studies from Iceland*, in *Int J Environ Res Public Health* (2020), 18:1, 158.

OGV during the course of their care, the extent to which this risk is manifested varies among individuals. Intersectionality does exacerbate this risk, irrespective of the geographical location where the care is provided.

Once experienced, the negative consequences of OGV are numerous. They can affect the quality of life of those affected for many years: "One in four women experience informal coercion during childbirth, and this experience is associated with a higher risk of postpartum depression and lower satisfaction with childbirth"[62]. Empirical literature documents numerous physical and psychological harms to victims: loss of appetite, eating disorders, nightmares and insomnia, chronic pain; anxiety, panic attacks, post-traumatic stress, suicidal ideation, depression; sexual dysfunction, dyspareunia, loss of libido; difficulties in bonding with children; loss of trust in the health care system and adoption of avoidance behaviours that can lead to further negative health outcomes[63].

There is undeniably a high occurrence of OGV worldwide, and it may well be underestimated by the current state of knowledge. Women and individuals experiencing this type of violence suffer physical, psychological and moral consequences that affect them and their relationships with their children, partners and wider community members. In this context, I will now turn to explore if, and how, law

62. Stepan Oelhafen *et al.*, *Informal coercion during childbirth: risk factors and prevalence estimates from a nationwide survey of women in Switzerland*, in *BMC Pregnancy Childbirth* (2021), 21:369: *https://doi.org/10.1186/s12884-021-03826-1*.

63. See, for instance, Haut conseil à l'égalité entre les hommes et les femmes, *Les actes sexistes durant le suivi gynécologique et obstétrical. Des remarques aux violences, la nécessité de reconnaître, prévenir et condamner le sexisme*, Haut conseil à l'égalité entre les hommes et les femmes, 2018, online: *https://www.haut-conseil-egalite.gouv.fr/sante-droits-sexuels-et-reproductifs/actualites/article/actes-sexistes-durant-le-suivi-gynecologique-et-obstetrical-reconnaitre-et*; Elizabeth Kukura, *Obstetric Violence*, in *Geo LJ* (2018), 106:3, 721; Stephanie Meyer *et al.*, *'We felt like part of a production system': A qualitative study on women's experiences of mistreatment during childbirth in Switzerland*, in *PLoS One* (2022), 17, e0264119; Ziba Taghizadeh, Abbas Ebadi, Molouk Jaafarpour, *Childbirth violence-based negative health consequences: a qualitative study in Iranian women*, in *BMC Pregnancy Childbirth* (2021) 21, 572.

can be a tool for preventing OGV and restoring justice to individuals who experienced it. The next part on my text aims to establishing the foundations of the research projects we are presently conducting. Therefore, I propose to present the evidence and arguments that, in our view, fuelled the need to undertake an in-depth study of law and OGV in Québec. On one hand, I seek to demonstrate that a mere awareness of legal rights is insufficient to ensure the delivery of healthcare that is more respectful of patients; on the other hand, I will illustrate that it is essential to document access to justice in order to better understand how the available formal remedies are (*un*)mobilised by stakeholders and victims, and to what extent they are or could be more effective in addressing OGV.

4. Law as a tool for preventing OGV and restoring a sense of justice for victims: an ongoing work

In Québec, the concept of obstetric and gynaecological violence is not mentioned in any legislative or regulatory text. Despite this absence in positive law and regulation, many rights exist that can – standardize the – prevent OGV from occurring, as I stated previously in part II: respect for dignity, right to integrity and autonomy, to privacy, right to consent or refuse a medical procedure. Furthermore, OGV has been given a significant recognition in the most recent perinatal plan of the Ministry of Health and Social Services; the «Back to Basics» plan explicitly mentions OGV, with a specific objective referring to it, namely «to create a culture of respectful, reassuring, non-discriminatory and non-stigmatising care"[64].

In order for law to be an effective tool in preventing the occurrence of OGV, I hypothesize that women have to know their rights and feel empowered to assert them. The assertion of the right must than be received and accepted by a healthcare professional that is also knowledgeable about the right, and does not feel threatened by the

64. Government of Québec, *Revenir à l'essentiel. Plan d'action en périnatalité et en petite enfance 2023-2028*, Ministry of Health and social Services, Québec, 2024, 14-15, online: *https://publications.msss.gouv.qc.ca/msss/document-003708/* (French only).

assertion. This series of prerequisites must be evaluated within the framework of Québec law and healthcare, for which we are currently gathering evidence[65]. However, data from other countries already suggests that there is a considerable distance to travel before achieving this goal.

The interaction between patients' rights and the relationship with their carers is a pivotal factor in understanding how patients express or claim their rights in the context of the care they receive. As early as 1986, the Swiss law professor Olivier Guillod stated: "In my view, patients' evident reluctance [to participate in medical decision-making] is not indicative of a lack of interest in their care or an abrogation of their autonomy. More often than not, it reflects a fear of annoying or contradicting the doctor"[66]. [my translation] Subsequent empirical studies on the subject have seemingly corroborated this assertion. For instance, in the context of active involvement in care decisions and the informed consent process, patients appear to adhere to a specific social norm of acting as a 'good patient', characterised by passive behaviour and an expectation that care decisions will be made independently by the carer[67]. In a similar manner, a study revealed that patients often refrain from seeking clarification or challenging the recommendations of their medical practitioners, primarily due to their apprehension of causing displeasure and, consequently, receiving substandard care[68],

65. We are currently conducting semi-structured interviews with individuals who have encountered OGV and have considered, or undertaken, formal recourse(s) as a consequence of this experience. As of 29 January 2025, 16 interviews have been completed and are undergoing analysis. Additionally, healthcare professionals, including doctors, nurses and midwives, will be surveyed on their knowledge of patients' rights, their responses to claims for these rights, and their general understanding of OGV.

66. Olivier Guillod, *Le consentement éclairé du patient. Autodétermination ou paternalisme?*, Éditions Ides et Calendes, 1986, 260.

67. Natalie Joseph-Williams, Glyn Elwyn, Adrian Edwards, *Knowledge is not power for patients: A systematic review and thematic synthesis of patient-reported barriers and facilitators to shared decision making*, in *PEC* (2014), 291.

68. Dominick L. Frosch *et al.*, *Authoritarian Physicians and Patients' Fear of Being Labeled 'Difficult' Among Key Obstacles To Shared Decision Making*, in *Health Aff* (2012), 31:5, 1030.

and even so in the context of pregnancy monitoring[69]. Therefore, if one can agree that women must be educated to know of their rights, the boundaries they are entitled to impose and the respect they are ought to expect, this education may not be enough to prevent the occurrence of OGV. To paraphrase the work of Natalie Jospeh-Williams *et al.*: patients' knowledge helps, but is not power.

If patients' knowledge is not enough, a focus on healthcare professionals' knowledge of women's rights may then be necessary. Despite the significance of fundamental rights such as integrity, autonomy and dignity in ensuring obstetrics and gynaecological care that respects women, there is a paucity of research on the extent to which healthcare professionals are aware of them[70]. There is an emphasis in the literature on the significance of educating carers about health law, and it is also highlighted that this education exhibits numerous deficiencies[71]. For instance, a UK-based study revealed that less than half of medical graduates expressed a reasonable or full level of confidence in their perceived knowledge of the legal principles that govern the concept of free and informed consent in healthcare[72]. A 2014 Australian study

69. Jacqueline A. Nicholls *et al.*, *Consent in pregnancy: A qualitative study of the views and experiences of women and their healthcare professionals*, in *European Journal of Obstetrics & Gynecology and Reproductive Biology* (2019), 238, 132.

70. Very few studies were conducted on that matter. See Mariola Czajkowska *et al.*, *Knowledge and opinions of patients and medical staff about patients' rights*, in *Ginekol Pol*, (2021) 92:7, 491; Dominika Cichonska-Rzeznicka, Paulina Agnieszka Trojak, *Knowledge of Patient's Rights among Students of the Faculty of Health Sciences of the Medical University of Łódź*, in *Journal of Health Study and Medicine* (2019), 2, 97; Seetharaman Hariharan *et al.*, *Knowledge, attitudes and practice of healthcare ethics and law among doctors and nurses in Barbados*, in *BMC Medical Ethics*, (2006): 7 *https://doi.org/10.1186/1472-6939-7-7*.

71. Erin Nelson, *Teaching Law to Students in the Health Care Professions*, in *Health Law Review* (2003), 11:2, 8; Brian A. Liang, *Medical Malpractice: Do Physicians Have Knowledge of Legal Standards and Assess Cases as Juries Do?*, in *U. Chi. L. Sch. Roundtable* (1996), 3, 59; Michael Preston-Shoot, Judy McKimm, *Towards effective outcomes in teaching, learning and assessment of law in medical education*, in *Medical Education* (2011), 45, 339.

72. Michael Preston-Shoot *et al.*, *Readiness for legally literate medical practice? Student perceptions of their undergraduate medico-legal education*, in *J Med Ethics* (2011), 37, 616.

also concluded that there are significant gaps in the legal knowledge of doctors practising in end-of-life care settings about issues affecting the continuation or cessation of life-sustaining treatment for patients who no longer have the capacity to consent to care[73]. In the province of Québec, a research has demonstrated that a lack of, or erroneous knowledge regarding the law on the part of medical professionals can compromise the effectivity of informed consent for patients[74]. A survey of healthcare professionals revealed that 58% of respondents lacked sufficient knowledge of the legal framework governing interprofessional care[75]. Furthermore, to my knowledge, there has been no assessment of healthcare professionals' perceptions of, and attitudes toward patients who claim, assert or clearly express their rights.

The law's effectiveness in relation to OGV can also be assessed in terms of its capacity to facilitate access to justice and provide redress to victims. Access to justice is an expression of the rule of law that characterises our society: "The crucial element in upholding the Rule of Law is that those involved in a justiciable legal dispute have clear paths to achieving just and timely outcomes, whether that is a court judgment, a tribunal decision, an agreement through a dispute resolution process, or otherwise"[76]. Literature on the meaning of justice and its conceptualisation by victim-survivors of gender-based violence emphasises that justice "relate[s] to accountability; fairness in outcome and process; protection from future harm; recognition; agency; empowerment; affective justice; reparation; and social transformation"[77].

73. Ben White *et al.*, *Doctors' knowledge of the law on withholding and withdrawing life-sustaining medical treatment*, in *MJA* (2014), 201:4, 1.

74. Audrey Ferron-Parayre, *Donner un consentement éclairé aux soins : réalité ou fiction?*, Éditions Yvon Blais, 2021; Audrey Ferron-Parayre, Catherine Régis, France Légaré, *Informed consent from the legal, medical and patient perspectives: the need for mutual comprehension*, in *Lex Electronica*, (2017), 1, 22.

75. Marie-Andrée Girard, Catherine Régis, Jean-Louis Denis, *Interprofessional collaboration and health policy: results from a Québec mixed method legal research*, in *Journal of Interprofessional Care* (2022), 36:1, 44.

76. The Canadian Bar Association, *Study on Access to the Justice System - Legal Aid*, House of Commons of Canada, 2016, 3.

77. Marianne Hester *et al.*, *What Is Justice? Perspectives of Victims-Survivors*

Our research project seeks to investigate the extent to which such a conceptualisation of justice is implemented for individuals having experienced OGV through four formal remedies available in Québec: medical liability, professional disciplinary boards (called 'professional orders' in Québec), criminal complaint[78] and complaint to the healthcare ombuds·wo·man. As I demonstrated earlier in this text, obstetrical and gynaecological violence is mostly due to a combination of systemic factors that interact to create and maintain conditions conducive to its occurence in clinical practices. In this sense, a detailed understanding of the accountability mechanisms underlying each formal recourse, and the potential for systemic accountability that they do (or do not) allow is necessary to give an adequate account of the real possibilities of access to justice in the context of OGV.

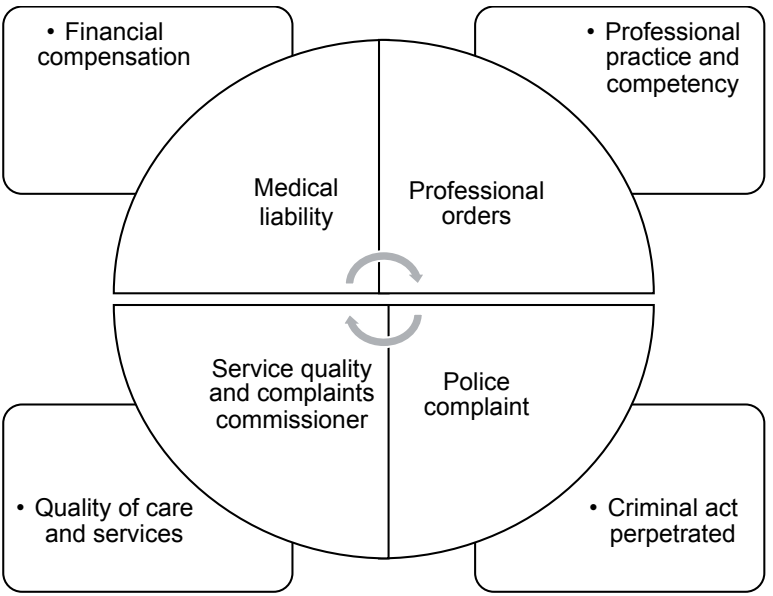

Figure 1 – Matrix of the formal recourses available in Québec to an individual victim of obstetrics or gynaecological violence

of Gender-Based Violence, in *Violence Against Women* (2023), 0:0: *https://doi-org.proxy.bib.uottawa.ca/10.1177/10778012231214772*.

78. A detailed examination of Canadian criminal law will not be provided here, as the matter is addressed in considerable detail by my colleague, Professor Dominique Bernier, in a separate text.

Figure 1 illustrates the complementary nature of the four remedies, and the main objective that each of them aims to achieve. Medical liability encompasses the legal process of pursuing legal action against the individual or entity deemed responsible for the infliction of harm, with the primary objective being the acquisition of financial redress[79]. Québec law in this area is based on a civil law system inherited from French colonisation. Professional orders have a mandate to ensure patients' protection, and they have inquiry requests' mechanisms to denounce practices that are considered inappropriate, unprofessional or unsafe by those who experience them[80]. Those mechanisms are designed to protect the public by ensuring the competence of the professionals authorised to practise. If, after an inquiry by the syndic, a complaint is upheld, it will be heard by a disciplinary council made up of two peers and a lawyer. Finally, Québec's *Act respecting the governance of the health and social services system* provides a mediation mechanism for health care users who are dissatisfied with the care or services they receive. The complaint examination procedure intends to improve the quality of care and services, with the overall objective of patient safety. For every institution, a local service quality and complaints commissioner is appointed to implement the complaint examination procedure within the institution[81].

The different perspectives and complementary objectives of the formal remedies available in Québec appear to provide adequate access to justice for women who experienced OGV. However, the evidence from the limited analysis of this issue, regarding medical liability and disciplinary councils in various jurisdictions, seems to indicate that those remedies are, at least partly, ineffective[82]. For

79. *Civil Code of Québec*, CQLR c CCQ-1991, s. 1457, 1458.

80. See *Professional Code*, CQLR c C-26, s. 126 and s.

81. *Act respecting the governance of the health and social services system*, CQLR c G-1.021, s. 671 and s.

82. Specifically, on OGV, see for instance Borges, *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, in *Duke Law Journal* (2018), 67, 827; Lisa Forsberg, *Childbirth, consent, and information about options and risks*, in Camilla Pickles, Jonathan Herring (eds.), *Childbirth, Vulnerability*

instance, an American author observes that the *#MeToo* movement has precipitated substantial legislative changes in several American states, resulting in the establishment of laws that stipulate that sexual consent is unequivocally expressed by a clear "yes", and that any other form of non-verbal communication (silence, gesture, etc.) must be interpreted as a "no". Yet, she notes that during the process of childbirth, "the old ways prevail" and informed consent is still presumed or obtained under coercion; the courts in medical liability cases are ill-equipped to understand the issues and redress the very biases and stereotypes that make OGV occur in the first place[83].

In the very specific context of vaginal examination without consent, and pertaining to English and Irish law, author Andrea Mulligan highlights that while negligence or battery could offer potential remedy, they are fraught with challenges in terms of application of the law and evidence. This leads her to suggest that "it may be better tackled outside of the law of tort altogether"[84]. In the United States, Farah Diaz-Tello also points out the financial and resources obstacles women face when they want to sue for obstetric or gynaecological violence, stating: "absent an injury to the baby or an extraordinary injury to the mother(beyond an unwanted or even unconsented medical invasion), the monetary value ascribed to harm to women during birth is low – or non-existent in the case of psychic injury – providing little

and Law. Exploring Issues of Violence and Control, Routledge, 2020, 161; Alexa Richardson, *The Case for Affirmative Consent in Childbirth*, in *Berkeley Journal of Gender, Law & Justice* (2022), 37, 1. On medicine more generally, see Timothy S. Jost *et al.*, *Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards*, in *Health Matrix* (1993), 3:2, 309, at 314; David A. Hyman, Mohammad Rahmati, Bernard Black, *Medical Malpractice and Physician Discipline: The Good, The Bad and The Ugly*, in *Journal of Empirical Legal Studies* (2021), 18, 131.

83. Alexa Richardson, *The Case for Affirmative Consent in Childbirth*, in *Berkeley Journal of Gender, Law & Justice* (2022), 37, 1, 3, 17-20.

84. Andrea Mulligan, *Redressing Unauthorized Vaginal Examinations through Litigation*, in Camilla Pickles, Jonathen Herring (eds.), *Women's Birthing Bodies and the Law – Unauthorized Intimate Examinations, Power and Vulnerability*, Hart Publishing, 2020, 171, 180.

incentive for attorneys from taking cases on a contingent fee basis"[85]. This certainly echoes to the general literature on tort law and civil liability that demonstrates that both the evaluation of the misconduct and the appreciation of the damages are fraught with biases that disadvantage women[86].

Regarding professional disciplinary complaints, although literature is scarce, I can report on one interesting paper focusing on professional complaints to England's Trusts. Rebecca Brione underlines that complaints mechanisms seem to be inadequate in investigating women's experiences and offering redress. Moreover, she stresses that women do not trust the system, perceiving it is more focused on protecting healthcare professionals than providing remedy[87]. In the end, after reporting on the care and legal pathways of several women, the author concludes with a remark that definitely summarizes the existing literature regarding OGV and redress mechanisms: "it is vital to grapple with the realities of healthcare practice and the intricacies of why neither regulatory nor legal processes yet seem to be offering women resolution and redress"[88].

85. Farah Diaz-Tello, *Invisible wounds: obstetric violence in the United States*, in *Reproductive Health Matters* (2016), 24, 56, 59.

86. Yifat Bitton, *Liability of Bias: A Comparative Study of Gender-Related Interests in Negligence Law*, in *Annual Survey of International & Comparative Law* (2010), 16:1, 63; Martha Chamallas, *Civil Rights in Ordinary Tort Cases: Race, Gender, and the Calculation of Economic Loss*, in *Loy. L.A. L. Rev.* (2005), 38, 1435; Lisa M. Ruda, *Caps on Noneconomic Damages and the Female Plaintiff: Heeding the Warning Signs*, *Case W. Rsrv. L. Rev.* (1993), 44, 197; Martha Chamallas, Linda K. Kerber, *Women, Mothers, and the Law of Fright: A History*, in *Mich. L. Rev.* (1990) 88, 814; Louise Langevin, *Responsabilité extracontractuelle et harcèlement sexuel : le modèle d'évaluation peut-il être neutre?*, in *Les Cahiers de Droit* (1995), 36:1, 99; Louise Langevin, *Mythes et réalités : la persnne raisonnable dans le livre 'Des obligations' du* Code civil du Québec, in *Les Cahiers de Droit* (2005), 46:1-2, 353.

87. Rebecca Brione, *Non-Consented Vaginal Examinations: The Birthrights and AIMS Perspectives*, in Camilla Pickles, Jonathen Herring (eds.), *Women's Birthing Bodies and the Law – Unauthorized Intimate Examinations, Power and Vulnerability*, Hart Publishing, 2020, 25, 35.

88. Ivi, 25, at 38.

In Québec, the ongoing analysis of court decisions and disciplinary councils' jurisprudence is certainly giving us analog results to the ones observed in the United Kingdom and the United States. However, beyond the scope of these court rulings, I believe it is imperative to delve into the experiences of patients, individuals who have initiated legal proceedings, and those who have contemplated such action but ultimately refrained. Asking women what they think about our justice system, what were the obstacles and the challenges they faced while exploring the possibility to sue or file a complaint, or during those procedures, is imperative for truly recognising the significance of this issue and successfully capitalise on opportunities to enhance the legal system and facilitate greater access to justice.

5. Concluding remarks

In this text, I have attempted to demonstrate the issues raised by obstetric and gynaecological violence, from its difficult conceptualisation to the growing body of evidence measuring its prevalence in Western societies, through the way by which law could be mobilised to prevent this form of violence and provide effective access to justice for victims. I have therefore explored three core concepts at the heart of obstetric and gynaecological violence, namely the infringement on fundamental rights, the systemic nature of OGV and its roots in gender-based violence. I have also highlighted that, far from being a marginal phenomenon, evidence drawn from multiple data sources point to the fact that OGV occurs frequently and affects many women. Individuals experiencing OGV will endure physical, psychological and relational consequences that can affect them – and their families – over the long term.

I have lastly invoked the assumptions underlying our current research project on the law and OGV, namely that law can prevent occurrence and remedy the consequences of OGV. However, both of these aims are harder to achieve than it seems. For prevention, there is still a paucity of understanding of the ways in which knowledge

of the law, its assertion and effective mobilisation can be achieved through patient-caregiver interactions. Certainly, more professional and lay public education is desirable, but may not be sufficient. Regarding remedies and access to justice, literature suggests that although recourses theoretically exist, their actual application to OGV cases is extremely difficult, with women also facing systemic and gender-based obstacles.

On that matter, the interviews we are conducting with women that experienced OGV and thought about or went through a complaint or a lawsuit will be paramount to offer us inestimable insight on what they are expecting of justice regarding OGV, what they experience through the different justice and complaints systems, and what could be done better. Already, the preliminary analysis of the interviews conducted so far are providing some interesting indications. First, in medical liability, the resources in terms of time, money and personal investment needed is an important barrier for women, yet alone in a context where, as I explained, the results of such a legal recourse are more than uncertain. Interestingly, we are starting to observe more class action lawsuits being brought against medical professionals, particularly regarding forced sterilisations imposed on Indigenous and Innu women[89]. These class actions, if they prove effective, could be a relevant procedural vehicle for alleviating resources issues for patients who experienced OGV.

Second, in the course of contemplating or effecting a complaint, the participants identify two precedent objectives: firstly, to comprehend the events in question, and secondly, to ensure that no other woman experiences the same treatment. Therefore, filing a complaint to the local services quality and complaints commissioner seems to be the more adequate recourse in order for them to meet these expectations. However, our preliminary data indicate that this recourse is little known and poorly understood by the participants. Furthermore, mistrust and a lack of confidence in the independence of the process have also been cited.

89. In Québec, see *Monday v. U.T.*, 2023 QCCA 1340 (motion for authorization to appeal a judgement granting the right to proceed with a class action dismissed).

In conclusion, our ongoing research will also examine the point of view of those involved in the judicial and complaints processes in order to understand their perceptions and attitudes towards the specific subject of obstetric and gynaecological violence. Their perspective on the capacity of their institution, and their own, to effectively address grievances arising from OGV cases is expected to facilitate the formulation of novel proposals aimed at enhancing access to justice.

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The Criminalization of Obstetrical Violence in Canadian Law: A Possible Solution? A Solution to Aim For?

Dominique Bernier

1. Introduction

This text will address the issue of the criminalization of obstetrical violence. This text is a written version of a presentation given at a symposium in Milan in April 2024. It is an exploration, an initial reflection on a vast project on obstetrical violence[1].

Two questions guided this presentation.

1. Can obstetrical violence, in certain cases, be qualified as a criminal offence? I will answer this question based on the rules of Canadian law and the specificities of obstetrical violence.
2. Is a criminal consequence or punishment of obstetrical violence the right course of action? This question will be answered in an exploratory and hypothetical way in the conclusion. At the end of this text, we'll also have a special thought for women who are victims of obstetrical violence in a context of systemic discrimination. I want, in the end, to open the discussion to a more socially rooted

1. This text reports on the work undertaken as part of the Justice VOG research programme, funded by the Canadian Institutes of Health Research (CIHR), the Social Sciences and Humanities Research Council of Canada (SSHRC), and the ministry of Women and Gender Equality of Canada.

and reflective perspective on the power relations that arise from obstetrical violence.

The aim of this text is not to send a punitive message to the people who practice medicine or care. Nor is the purpose of this text to diminish the experience of the person who give birth and of the people who accompany them. The objective of this text is to help understand that liability is a legal concept that can take many forms. While the civil or professional liability of caregivers is sometimes involved, in some cases the law also provides for more coercive forms of punishment. This text will therefore be fairly positivist in nature. I will examine the law and its limits. But I believe that a positivist analysis would be insufficient, and that other reflections must follow on from this first step.

For the definition of obstetrical violence, we refer to our colleague's text in this book.

2. Canadian criminal law : some context

Canadian criminal law is based on the English Common Law tradition. While Canadian criminal law since has gone its own way, certain English Common Law interpretive principles are still present. Criminal law jurisdiction is federal[2], so the same criminal code applies across Canada.

Canadian criminal law is public law and completely separated from civil law procedure. The prosecutor represents the State and must prove the guilt of the accused person beyond all reasonable doubt. The accused is presumed innocent. Canadian criminal law is under the aegis of the Canadian Charter of Rights and Freedoms, particularly sections 7 to 14, which provide constitutional protections for accused persons from pre-trial detention to execution of sentence[3]. These principles remain at the heart of any interpretation of criminal law to ensure legality and protect accused person against excessive coercive power by the state.

2. Jean Turgeon, *Introduction au droit pénal général*, *Droit pénal*, Lexis, Fascicule 1, mise à jour 2023.

3. *Ibidem*.

Two broad categories of offences can be considered in the context of obstetrical violence.

The first category concerns offences involving subjective intent of the perpetrator, more specifically the offences against personal integrity[4]. The second category concerns offences committed in a context of negligence where the behavior is a marked deviation from a reasonable person.

3. Assault and sexual assault

Assault is an offence that simply involves the use of force without the consent of the victim.

265 (1) A person commits an assault when
- **(a)** without the consent of another person, he applies force intentionally to that other person, directly or indirectly;
- **(b)** he attempts or threatens, by an act or a gesture, to apply force to another person, if he has, or causes that other person to believe on reasonable grounds that he has, present ability to effect his purpose; or
- **(c)** while openly wearing or carrying a weapon or an imitation thereof, he accosts or impedes another person or begs.

[…][5]

Assault is a broadly worded offences that include a non-restrictive definition of the use of force[6]. Obviously, there are forms of aggravated assault when there is bodily harm or injury[7].

Actions taken in the context of care (or obstetrical violence) that would be made against a person's consent could very easily meet the requirements of the provision if it can be shown that the application of force is involved. Each situation must be analyzed on its own merits. Not every case of disrespect or disregard of consent meets the criminal

4. The intent is formed by the accused person at the time of committing the punishable acts.

5. S. 265 Canadian Criminal (RSC, 1985, c. C-46).

6. *Ibidem*.

7. *Ibidem.*

standard of assault, but certain abusive or violent behaviors could qualify as this offence.

In Canadian law, I believe an important distinction must be mentioned. Obstetrical violence would not necessarily be limited to the general definition of assaults. One of the declensions of assault, in the Criminal Code since the 1980s, concerns sexual violence. Socially, we've chosen to move away from rape offenses or offenses with overly precise behavioral definitions. The law has been amended to include a broadly defined behavior that includes all forms of sexual assault.

In Canadian law, sexual assault is an assault in a sexual context.

A conviction for sexual assault under *s. 271(1)* of the *Criminal Code* requires proof beyond a reasonable doubt of the *actus reus* and the *mens rea* of the offence. A person commits the *actus reus* if he touches another person in a sexual way without her consent. Consent for this purpose is actual subjective consent in the mind of the complainant at the time of the sexual activity in question: *Ewanchuk*. As discussed below, the *Criminal Code*, s. 273.1(2) , limits this definition by stipulating circumstances where consent is not obtained[8].

Obviously, sexual intent in a medical context where inappropriate gestures are committed easily qualifies as a sexual assault offence. But, more indirectly, other forms of obstetrical violence could also qualify. While this may seem surprising at first glance, given that the medical context does not necessarily involve sexuality and the violence traditionally associated sexual assault, Canadian law gives us some indication of the possible use of this type of offence.

The interpretation of sexual assault is very broad and open-ended. Case law confirms that these offences are not intended solely to punish a person seeking sexual gratification or a particular sexual intent. It's not just about touching sexual parts of the body, but also about the context, the situation and the words spoken during the event[9]. Author Julie Desrosiers reminds us, in this perspective, that

8. R. v. Hutchinton, 2014 SCC 19.

9. Julie Desrosiers, Geneviève Beausoleil-Allard, *L'agression sexuelle en droit canadien*, 2e éd., Éditions Yvon Blais, 2017, chapter 1.2.

there would be an examination of the reasonableness of the sexual nature of the act[10].

Given the nature of the gestures in the context of obstetrical violence (in some situations), the offences that could be prosecuted would fall under the category of sexual assault[11]. Again, each situation must be analyzed on its own merits. Certain behaviors could qualify as sexual assault. To some extent to be explored.

In both cases, assault and sexual assault, the person's consent is at the heart of the offence. It is the subjective absence of consent by the victim that must be examined.

To summarize in a few words the text of the law and, above all, 50 years of Canadian jurisprudence, this consent must meet the following requirements[12], which should be noted in the context we are dealing with here:

- Real, free and informed.
- "The accused induces the complainant to engage in the activity by abusing a position of trust, power or authority[13]".
- "The complainant expresses, by words or conduct, a lack of agreement to engage in the activity; or […] the complainant, having consented to engage in sexual activity, expresses, by words or conduct, a lack of agreement to continue to engage in the activity[14]".
- Continuous and can be revoked.
- The person must be conscious.

The absence of consent is becoming the cornerstone of many examples in case law concerning the medical context in general.

10. Ivi, chapter 1.3.

11. R. c. Lussier, 2005 CanLII 2338 (QC CQ); R. c. Litchfield, 1993 CanLII 44 (CSC), [1993] 4 RCS 333; Nguyen c. R., 2005 QCCA 13; Lapointe c. La Reine, 2001 CanLII 39803 (QC CA); R. v. Ateyah, 2023 ONSC 5286; R. v. C.D., 2023 ONCA 790 : non-medical purpose; R. v. S.L., 2020 ONSC 4036; R. v. Daniel Robert Marshall, 2013 ONSC 2603; R. v. Doodnaught, 2013 ONSC 8022.

12. Op. Cit., note 9.

13. S. 273 Canadian criminal Code.

14. S. 273 Canadien criminal Code.

What the person understood, the nature of the care given, and the nature of the care explained are all elements that can take on importance.

The central issues raised in decisions where cases were deemed more complex and where it was necessary to question grey areas: Was the touch or maneuver justified on the medical plan? Did the victim consent? What did the victim agree to?

A case such as the one before us, involving a doctor-patient relationship, highlights the importance of considering all the circumstances of the accused's alleged conduct[15]. Certainly, medical evidence will be important in assessing the nature of the accused physician's conduct.

However, in determining whether a complainant consented to what occurred, the court must also be careful not to discount the testimony of a patient who complains of sexual assault, and not to underestimate the vulnerable situation in which a patient who is being treated by a doctor often finds herself. With this in mind, let's quote passages from the decision R. v. Daniel Robert Marshall, 2013 ONSC 2603

[7] To prove the charges beyond a reasonable doubt, the crown must show as to the sexual assault that there was intentional touching of a sexual nature and the absence of consent. As to the sexual interference counts, the crown must prove that there was intentional touching of the complainants who were under the age of either 14 or 16, depending on the date of the offense, for a sexual purpose.

[8] Because sexual assault is a crime of general intent, the crown need not prove a specific intent with respect to the sexual nature of the assault because it forms part of the actus reus. The test is therefore an objective one where all the circumstances surrounding the conduct in question will be relevant to the question of whether the touching was of a sexual nature and violated the complainants' sexual integrity. […]

[15] In addition to the perceptions of the complainants, the crown relied on several factors which I have collected into three groups to support the allegation that the touching was of a sexual nature:

- that there was no medical purpose for the genital examinations;
- that even if there was a medical purpose for an initial examination, the

15. R. c. Litchfield, 1993 CanLII 44 (CSC), [1993] 4 RCS 333.

- examinations happened with unwarranted frequency; and
- that the examinations were performed in improper circumstances with Dr. Marshall using improper methods.

In the same perspective, let's cite R. v. Ateyah, 2023 ONSC 5286:

A conviction for sexual assault involves proof beyond a reasonable doubt that the accused touched the complainant for a sexual purpose without their consent. In a situation where a doctor is examining a patient with their consent, there will be no sexual assault if the examination is done for a legitimate medical reason. In other words, if the doctor has a valid medical purpose and an objectively legitimate reason for examining an intimate part of a patient's body the examination is not sexual. In order for there to be a sexual assault in the case of a consensual medical procedure, the doctor's touching must have been used to sexualize the interaction. A patient can only provide consent to a bona fide medical examination conducted for a legitimate medical purpose .

In short, the actions associated with obstetrical violence can be assault or sexual assault when there is a form of subjective intention associated with the action and an absence of consent from the victim. Consent will undoubtedly be at the heart of the analysis, as will the nature of the care given and the specific context of each case.

4. Negligence

The second category of possible offences in the context of obstetrical violence is negligence. This category of offence in the Canadian Criminal Code involves conduct that deviates from that of a reasonable person in the same circumstances[16].

219 (1) Every one is criminally negligent who
- **(a)** in doing anything, or
- **(b)** in omitting to do anything that it is his duty to do,

shows wanton or reckless disregard for the lives or safety of other persons.

16. R. v. Beatty, 2008 SSC 5; R. v. Roy, 2012 SSC 26; R. v. Javanmardi, 2019 CSC 54.

(2) For the purposes of this section, ***duty*** means a duty imposed by law.

220 Every person who by criminal negligence causes death to another person is guilty of an indictable offence and liable

(a) where a firearm is used in the commission of the offence, to imprisonment for life and to a minimum punishment of imprisonment for a term of four years; and

(b) in any other case, to imprisonment for life.

221 Every person who by criminal negligence causes bodily harm to another person is guilty of

(a) an indictable offence and liable to imprisonment for a term of not more than 10 years; or

(b) an offence punishable on summary conviction.

In cases of negligence, an objective analysis is carried out. The actions of the person whose criminal responsibility is being questioned are compared with those of a reasonable person in the same circumstances. It's not the real intentions that count; subjective intentions are put aside.

Instead, the analysis focuses on conduct and its circumstances. As the Supreme Court of Canada explains in a decision concerning the actions of a naturopathic doctor:

> [19] The *actus reus* of criminal negligence causing death requires that the accused undertook an act — or omitted to do anything that it was his or her legal duty to do — and that the act or omission caused someone's death.
>
> [20] The fault element is that the accused's act or omission "shows wanton or reckless disregard for the lives or safety of other persons". Neither "wanton" nor "reckless" is defined in the […], but in *R. v. J.F.*, [2008] 3 S.C.R. 215, this Court confirmed that the offence of criminal negligence causing death imposes a modified objective standard of fault – the objective "reasonable person" standard (paras. 7-9; see also *R. v. Tutton*, [1989] 1 S.C.R. 1392, at pp. 1429-31; *R. v. Morrisey*, [2000] 2 S.C.R. 90, at para. 19; *R. v. Beatty*, [2008] 1 S.C.R. 49, at para. 7).

The court's reasoning concerns manslaughter but applies in a similar way to other negligence offences. In the case of death, the deviation must be marked and significant in relation to the reasonable person, but for the rest it's similar. The marked deviation from the reasonable person is at the heart of each variation of this broad category of offences

The conduct must be related to a legal duty to act[17]. In the context of the medical profession, this duty to act derives from the laws and ethical requirements that govern the profession[18].

We won't go into a full analysis of what might constitute a negligent gesture in the context of gestures associable with obstetric violence. But we do feel it's important to mention this type of offence, which seeks to punish negligence that endangers, injures or cause death (in this case, the offense is manslaughter).

Here again, the rules of medical practice, the standard of care and the circumstances of a given type of care will be considered in assessing what is reasonable and what is a criminal breach of the standard.

5. Our reflections

To the question of whether obstetrical violence can be criminally prosecuted, the answer is yes. Obviously, this highly theoretical answer requires several nuances, both in terms of the pragmatic operation of criminal law, and in terms of the appropriateness of using this coercive system. But an analysis of the provisions of the Criminal Code shows that certain offences are possible. The act must be associated with some kind of intent (the definition of which varies from offence to offence) or sufficiently negligent behavior to become a criminal act.

This text does not take into consideration the evidentiary and procedural issues that may be associated with the laying of charges in these contexts. To mention just a few elements, to be charged, there must be a police investigation and the exercise of prosecutorial discretion which authorizes the charges. It is difficult for us to comment on how this discretion might be exercised, especially in the medical or the care context. Further research, with a more qualitative methodology, for example, would be necessary to validate the operationalization of these

17. Marie-Ève Sylvestre et Manon Lapointe, *Élément mental de l'infraction : mens rea objective*, *Droit pénal*, Lexis, Fascicule 4, mise à jour 2022.

18. R. c. Javanmardi, [2019] 4 RCS 3; R. v. Orpin, 2002 CanLII 23600 (ON CA); R. v. Swanney, 2006 BCSC 1766 (CanLII); R. v. Flynn, 2017 ONSC 2290 (CanLII); R. v. Christopher Marchant and Steven Snively, 2022 ONSC 263.

charges beyond the hypotheses. It should be noted that, according to the research carried out by the team associated with the project, very exceptional cases are involving the criminal responsibility of doctors or medical staff.

On another note, victims are always faced with issues of credibility. Myths and stereotypes have always existed[19]. We can easily imagine in this context that victims might face the same doubts about their experiences in a medical context. Victims who continue to face these prejudices may find legal paths more difficult. To file a complaint, you must first be believed or supported in the process. We still have a long way to go on this point.

This is particularly true for victims of systemic discrimination. In Canada, forced sterilizations of indigenous women are increasingly being brought to light by researchers and non-governmental organizations. Indigenous women were forced to undergo sterilization without their informed consent. The stories coming out of some communities are appalling. This obstetrical violence is understood in the context of colonialism and discrimination experienced by aboriginal women[20].

19. "It is against the standard of a "reasonable person" that the jury will have to assess the dangerousness of any unlawful act. It is against the standard of a "reasonably prudent person" that the jury will have to assess whether Ms. Flynn's conduct was a marked and substantial departure from the norm. The "reasonable" or "reasonably prudent" person may be particularized to the circumstances of the accused and the nature of the conduct at issue. In this case, that may be the reasonable or reasonably prudent member of an ICU team, whether a nurse or health practitioner. It is against this standard, rather than against the standards and practices of Ms. Flynn's colleagues at GBGH on March 2, 2014, that Ms. Flynn's conduct must be judged. (par a15) The standard of care, whether on the basis of a member of an ICU team, a nurse or a health practitioner, is outside the ordinary knowledge and experience of the trier of fact. This standard needs to be assessed through expert evidence on accepted medical practices and on the basis of relevant statutory requirements." R. v. Flynn, 2017 ONSC 2290.

20. Basile, Suzy, Patricia Bouchard, *Consentement libre et éclairé et stérilisations imposée de femmes des Premières Nations et des Inuit au Québec. Rapport final*, Wendake, Commission de la santé et de services sociaux des Premières Nations du Québec et du Labrador, 2022: *https://files.cssspnql.com/s/oPVHFaKIp8uw5oF*.

Other groups of women who experience systemic discrimination may also raise the question of how to respond to obstetrical violence. I think of black women, whose suffering has been shown to be neglected, and for whom there is a higher risk of complications during birth[21]. I also think about women prisoners who are receiving gynecological and obstetrical care.

Now, this brief exploration raises some very important questions. Is criminal law an option in cases of obstetrical violence? Is it the socially desirable solution? Criminal law must certainly retain its exceptional criterion.

In our view, prevention and training are the best ways forward. In fact, the project we are part of is a step in this direction. But we must recognize that, in certain contexts, dissuasion and punishment could be considered.

If from an individual perspective, I can doubt the use of criminal law as a coercive tool. When obstetrical violence is organized, structured or discriminatory (whether intentionally or not), should it nevertheless be punished as a crime? We won't give an answer to this question for the moment, but we do want to mention the importance of addressing it in this reflection on the punishment and consequences of obstetrical violence.

21. *https://nwac.ca/policy/forced-sterilization*.

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Obstetric and Obgyn Violence: A Persistent Challenge to Women's Rights in Reproductive Healthcare

Marilisa D'Amico

1. Introduction: Why Discussing Gynecological and Obstetrical Violence

Obstetric violence[1], a term gaining increasing recognition, pertains to the mistreatment and violation of pregnant individuals' rights during childbirth and reproductive healthcare.

Historically rooted in patriarchal medical practices[2] that treat pregnancy as a pathology rather than a natural process, this violence

1. On the use of the term 'obstetrical violence', see A.C. Ferrão *et al*., *Analysis of the Concept of Obstetric Violence: Scoping Review Protocol*, in *Journal of Personalized Medicine*, 2022. See also, M.A. Bohren *et al*., *The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review*, in *Plos Medicine*, 2025, instead proposes the expression "mistreatment of women" as a broader, more inclusive term that better captures the full range of experiences women and health care providers have described in the literature.

2. On the topic of gender medicine, see F. Rescigno, *Per un* habeas corpus *"di genere"*, Editoriale scientifica, 2022; F.G. Pizzetti, *Costituzione e "medicina di genere"*, in *Notizie di Politeia*, 2023; B. Liberali, *I diritti riproduttivi e la medicina di genere*, in M. D'Amico, B. Liberali (a cura di), *Gli strumenti della parità di genere*, Editoriale scientifica, 2024, 137 ss.

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was originally understood as a form of violence occurring when pregnant women are treated as patients "incapable" to excercise their right to self-determination, emotionally unreliable, undeserving any information and involvement in choices on childbirth and labor.

It manifests in both overt and subtle ways, from verbal abuse to the violation of informed consent, obstetric violence strips women of their autonomy, reducing their experiences to medicalized procedures governed by systemic control over their bodies.

In fact, as it will be possible to see, obstetrical violence can be understood as a manifestation of the more global phenomenon of gender-based violence, which exposes institutional violence within maternity care settings. The concept of obstetrical violence in fact intends to address commonly and daily practised practices that manifest themselves in medical facilities in the form of violence, as approaches to motherhood that dehumanise women – as well as trans and non-binary people[3]. In fact, it consists of the violation of women's rights during childbirth, during labour and during healthcare services in any way related to the sexual and reproductive sphere, by medical, obstetric and nursing staff.

3. B. Pezzini, *Transessualismo, salute e identità sessuale*, in *Rass. dir. civ.*, 1984, II, 465 ss.; A. Lorenzetti, *Diritti in transito. La condizione giuridica delle persone transessuali*, FrancoAngeli, 2013; B. Liberali, *Il transgenderismo fra diritto alla salute e diritto all'identità di genere: problematiche attuali e prospettive future*, in *Federalismi*, n. 12, 2025. Particularly relevant in this regard is the recent judgment of the Constitutional Court, No. 143 of 2024, in which the Court ruled on two issues of constitutional legitimacy concerning gender affirmation processes. The Court recognized the centrality of the right to health for transgender individuals, affirming that insofar as it may lead to differential treatment or compromise a person's physical and psychological well-being, this condition [more precisely: non-binarism] may also raise concerns regarding the respect for social dignity and the protection of health, in light of Articles 3 and 32 of the Constitution. For a commentary on the judgment, see the contributions contained in N. Posteraro, B. Liberali (a cura di), *Sul non binarismo di genere e sull'autorizzazione giudiziale a effettuare gli interventi chirurgici di affermazione di genere. La sentenza della Corte costituzionale n. 143 del 2024*, Editoriale Scientifica, 2025.

The concept, emerging through the initial legislative responses of Latin American countries, addresses an issue closely related to the doctor-patient relationship.

In 2007, Venezuela became the first country to legally recognise the term 'midwifery violence', providing an official definition outlined in the *Ley Orgánica sobre el derecho de las mujeres a una vida libre de violencia*, in art. 15, where we read that obstetrical violence consists of the "appropriation of women's bodies and reproductive processes by health personnel, which is expressed as dehumanised treatment, abuse of drugs, and to convert natural processes into pathological ones, bringing with it the loss of autonomy and the ability to freely decide on one's own body and sexuality, with a negative impact on the quality of women's lives".

In the same law, Article 51 fills in the content of the concept of obstetrical violence, stipulating that it manifests itself in acts of inappropriate and ineffective assistance in obstetrical emergencies such as forcing the woman to lie on her back with her legs raised when an upright birth is feasible; preventing early mother-baby union and/or early breastfeeding without medical justification; obstructing the presence of a partner and, in general, interrupting the natural process of a low-risk birth without medical indication and/or without the woman's consent.

The Latin American context is not the only one to have recognised – or attempted to recognise – the concept of obstetric violence[4]. Although not to the same extent, in 2014, the World Health Organisation adopted a statement titled The Prevention and Elimination of Abuse and Disrespect during Assisted Delivery in Hospital Facilities, although it never explicitly referred to obstetric violence. As will be discussed in more detail below, the statement contained a list of 'disrespectful

4. On this topic, see M. Sadler *et al.*, *Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence*, in *Reproductive Health Matters*, 2016; C.R. William *et al.*, *Obstetric violence: a Latin American legal response to mistreatment during childbirth*, in *An International Journal of Obstetrics and Gynaecology*, 2018; A. Castro, *Witnessing Obstetric Violence during Fieldwork: Notes from Latin America*, in *Health Hum Rights*, 2019; M. Sadler, *Obstetric Violence, a Latin American Concept*, in London, 2025.

and abusive treatments', such as "outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedure (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violation of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay".

Although recognised, in other legal contexts, as a form of gender-based violence and therefore assumed as an autonomous criminal offence – towards which the State can direct measures not only of punishment, but also of prevention and contrast – the Italian panorama does not seem to be moving in the same direction, despite the fact that the problems underlying the concept of gender-based violence are equally widespread in the context of our State. The absence of a general international consensus in the definition of obstetrical violence means that it is difficult to trace its perimeter.

For this reason, this contribution aims to offer a new perspective on 'ancient' issues related to reproductive rights, in an attempt to frame issues such as difficulties in accessing parenthood, forced sterilisation and the free exercise of the right to access voluntary termination of pregnancy within the socio-political concept of Ob-Gyn violence.

The in-depth study in this sense – it should be pointed out – moves in the awareness that the very concept of obstetrical violence is nevertheless a concept with still undefined boundaries.

Discussing obstetrical and gynaecological violence, then, helps to target more appropriately forms of violence that have to do with the woman's body and self-determination.

2. Ob-Gyn Violence, from definitions to its broad manifestations

As anticipated, the absence of a general international consensus on the concept of obstetrical violence entails the emergence of a first major difficulty in addressing this manifestation of gender-based

violence, namely the difficulty in clearly defining its perimeter and contours.

Obstetric and gynecological violence encompasses a wide spectrum of behaviors and practices that violate women's rights, dignity, and autonomy within healthcare settings, which have to do with the (still) paternalistic nature of the doctor-patient relationship.

These practices often stem from deeply entrenched historical and cultural biases that have marginalized women's bodies and their capacity to make informed decisions about their health[5]. Historically, the medical field has been shaped around a male-centric model, treating the male body as the default and neglecting the unique physiological and psychological experiences of women.

This has led to significant gaps in understanding and addressing female-specific conditions, such as polycystic ovary syndrome (PCOS), endometriosis, and vulvodynia, leaving many women without accurate diagnoses or adequate care. Such structural deficiencies have not only perpetuated neglect but have also fostered a medical culture where women's health is undervalued, and their voices are often silenced.

Within this context, obstetric and gynecological violence can take on various forms. Recent studies have attempted to offer a systematic classification of practices that can be understood as 'abusive' and that can therefore guide the identification of obstetrical violence. In particular, it is possible to divide such acts into seven categories: physical abuse; non-consenting care; non-confidential care; undignified care; discrimination based on specific attributes of the women; neglect, denial or negligence of care and detention in health facilities[6].

However, as the doctrine points out, this classification does not capture the larger dimension of the term 'violence'[7], which

5. On this topic, M. D'Amico, B. Liberali (a cura di), *Gli strumenti della parità di genere*, Editoriale Scientifica, 2024; F. Rescigno, *Per un* habeas corpus *"di genere"*, Editoriale Scientifica, 2022.

6. D. Bowser, K. Hill, *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis*, USAID–TRAction Project, Harvard School of Public Health, 2010.

7. Cfr. M.A. Bohren *et al.*, *The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review*, cit., where

encompasses cultural, social and institutional aspects[8], including the disempowerment of women with regard to decisions on motherhood and health facilities.

Women's rights might also be affected by means of the resort to discriminatory and offensive language. It possesses a strong impact in impairing human rights and, especially in the field of obgyn and obstetric violence, women are often targeted with offensive expressions and insults while hospitalized or subjected to diagnosis and even consultations[9]. Verbal violence is pervasive and insidious, manifesting in insults, belittling remarks, and dismissive attitudes during consultations, labor, or childbirth. Women are often accused of being overly emotional or incapable of enduring pain, with their concerns and preferences dismissed as irrational. Such treatment reinforces harmful stereotypes about women's fragility and diminishes their confidence in medical professionals, leaving lasting emotional scars.

Physical violence, on the other hand, includes invasive procedures performed without consent or adequate justification, such as

the authors underline that term *obstetric violence*, while rooted in feminist movements and human rights discourses in Latin America, has been criticized for its potentially polarizing nature in cross-cultural or institutional dialogues. Its implication of intentional harm may hinder productive engagement with key stakeholders such as healthcare professionals and policymakers – actors whose collaboration is essential to promote systemic change in maternal care practices. See also, C. Pickles, *Autonomy, Violence, and Consent in the Obstetric Field*, in *Hypatia*, vol. 35, n. 2, 2020, 633, where the author points out that the World Health Organization's preference for the term *mistreatment* – to the exclusion of *abuse* and *obstetric violence* – risks depoliticizing the issue and obscuring its gendered and structural dimensions. Critics argue that this narrower terminology may disconnect childbirth violations from broader frameworks of gender-based violence, despite extensive feminist scholarship that frames obstetric violence as a manifestation of systemic inequality embedded within institutional maternity care.

8. M. Sadler, M. Leiva, I. Olza *et al.*, *Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence*, in *Reproductive Health Matters*, vol. 24, n. 47, 2016.

9. On the issue of discriminatory language, see M. D'Amico, *Parole che separano. Linguaggio, Costituzione, Diritti*, Raffaello Cortina Editore, 2023.

unnecessary cesarean sections, forced episiotomies, or repeated vaginal examinations conducted without explanation. Over-medicalization, particularly during childbirth, further exacerbates this form of violence, as natural processes are pathologized and subjected to excessive interventions that prioritize medical authority over the well-being and autonomy of the patient.

One of the most profound violations lies in the systemic abuse of authority and the disregard for informed consent. Women are frequently excluded from decision-making processes about their own bodies, coerced into undergoing procedures they do not fully understand, or entirely ignored when expressing their preferences. This appears even more significant if one considers that, recently, in Italy – and in other Western realities – there has been an increase in the unnecessary use of medical practices in the so-called 'birth path'[10]. The inappropriate use of certain practices derives from a strong gap between evidence and clinical practice, which can certainly be reduced by providing communication in advance regarding the possibility that certain practices may in fact be useful, especially in emergency contexts. Equally, appropriate information should be provided regarding the content of such practices, in order to allow a free and informed choice on the part of pregnant women.

This hierarchical approach to care places disproportionate power in the hands of healthcare providers, undermining the foundational ethical principles of respect and autonomy in medical practice. Consequently, informed consent assumes an even more significant role if it is understood as a tool to allow women to consciously self-determine with respect to the practices to which they may be subjected, even in cases of urgency.

Consider, for example, the issue of caesarean section.

10. V. Basevi, C. Morciano, *Evidence-based recommendations for physiological pregnancy care: the Istituto Superiore di Sanità (ISS) model*, in *RIMeL - IJLaM*, Vol. 6, No. 2, 2010, where they underline that a key issue in the process of the application of clinical guidelines lies in their uneven quality: there is no internationally accepted and shared standard for their development, and only a limited number of organizations provide detailed descriptions of the methodology used in formulating their recommendations.

Italy appears among the countries with the highest rates of caesarean sections, globally. Cesarean births are more frequent in women with Italian citizenship than in foreign women, at 32.4% compared to 27.2%.

There is also significant variability by geographical area and between regions, ranging from 19.6% in the Autonomous Province of Trento to 50% in the Campania Region[11].

Language plays a critical role in perpetuating these dynamics, both in direct interactions and in the broader framing of medical practices. Discriminatory and condescending language directed at women during labor or gynecological care compounds feelings of disempowerment and isolation, while systemic biases embedded in medical terminology and discourse frame childbirth and pregnancy as risks to be managed rather than natural processes to be supported. This framing justifies excessive intervention and further marginalizes women's voices, reinforcing the notion that they are passive recipients of care rather than active participants in their own healthcare decisions.

The consequences of these forms of violence extend beyond individual experiences, creating systemic barriers that undermine women's health and reinforce gender inequality. Women who endure obstetric violence often suffer long-term psychological effects, including anxiety, depression, and post-traumatic stress disorder, which can deter them from seeking further medical care. At the societal level, obstetric violence reflects a broader pattern of patriarchal norms that prioritize institutional authority over individual rights, perpetuating cycles of disempowerment and neglect. Addressing these issues requires not only changes in clinical practices but also a reevaluation of the cultural and legal frameworks that sustain them, ensuring that women's voices, autonomy, and dignity are central to reproductive healthcare.

11. R. Boldrini, M. Di Cesare, F. Basili, G. Campo, R. Moroni, M. Romanelli, E. Rizzuto, *Bithplace: Birth certificate at birth (CedAP) – Analysis data 2020, Ministry of Health*, 2021 (*http://www.salute.gov. it/statistiche*).

3. Legal responses from South America to Europe

The recognition and regulation of obstetric and gynecological violence within legal frameworks remain inconsistent and incomplete globally. Venezuela has been a pioneer in this area, becoming the first country to legally define obstetric violence through its *Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia* in 2007. This landmark legislation frames obstetric violence as the appropriation of women's reproductive processes by healthcare personnel, characterized by dehumanizing treatment, excessive medicalization, and the pathologization of natural processes like pregnancy and childbirth. This legal definition emphasizes the impact of these practices on women's autonomy, dignity, and quality of life, offering a model for recognizing and addressing the systemic nature of such violence.

The Venezuelan push to develop a legal and legislative response to the medicalization of childbirth and practices encompassed by the concept of obstetric violence has sparked a series of legislative responses at both national and global levels. In 2014, the World Health Organization issued a statement titled *The Prevention and Elimination of Abuse and Disrespect during Childbirth in Health Facilities*, aiming to highlight how issues of abuse and lack of informed consent during childbirth are not merely healthcare problems, but rather significant human rights issues. Forms of violence in the delivery room and within the doctor-patient relationship represent a major violation of women's rights, resulting in a substantial infringement of fundamental human rights such as the right to health, life, physical integrity, and freedom from all forms of discrimination.

The WHO's goal was to draw the international community's attention to a problem that often manifests in subtle forms, deeply rooted in the paternalistic doctor-patient relationship that is frequently found in other medical contexts, as well as in the historical and cultural silence surrounding the suffering attributed to childbirth and, more generally, to pregnancy.

In 2019, the Council of Europe addressed the issue of obstetric violence, defining it as a violent and sexist practice that can occur during childbirth and in medical situations closely related to the reproductive

sphere. In this regard, the Council of Europe links forms of obstetric violence to a manifestation of gender-based violence[12], constituting a violation of women's right to live a life free from violence. Interestingly, the Council of Europe has included in the concept of obstetrical violence not only "violent practices", but also those that 'may be perceived as such': in both cases, they are identified as "unsuitable or unauthorized acts, such as episiotomies or vaginal palpations performed without consent, pressure on the uterine fundus or failure to use anesthesia for painful interventions", to which "sexist behavior during medical examinations" is also added.

Consequently, the Resolution no. 2306 of 2019 calls on member states to adopt legislative measures to ensure effective prevention and sanctioning of all forms of obstetric violence, seen as a reflection of a patriarchal culture still dominant in society, particularly in the medical field, as well as the result of a lack of proper education and training and a lack of respect for women's equality and human rights.

The European Parliament defined midwifery violence as a specific form of gender-based violence also in 2021, on the occasion of the Resolution on sexual and reproductive health and rights in the EU, within the framework of women's health, combining the guarantee of underlying rights, in particular, informed consent. Devoting a specific paragraph to maternity care, pregnancy and childbirth, the Resolution calls on member states to 'ensure respect for the rights and dignity of women during childbirth', emphasizing the importance of protecting not only the right to health and self-determination, but also personal dignity.

These international documents are significant insofar as they make it possible, firstly, to frame gynecological and obstetrical violence within

12. On the topic, see also P. Quattrocchi, *Violenza ostetrica. Le potenzialità politico-formative di un concetto innovativo*, in *EtnoAntropologia*, n. 1, 2019, which highlights that obstetric violence constitutes a complex phenomenon, and this very complexity makes it intellectually "good to think with". From a political and cultural standpoint, framing obstetric violence as a form of violence inflicted upon women *as* women – a particularly relevant issue today – invites a broader reflection that extends beyond hospitals and delivery rooms, prompting critical inquiry into the foundational values underpinning our societies.

the more general framework of gender-based violence and, secondly, to understand the further declinations of a form of violence that is closely linked to women's health.

4. Italy, Women's Rights and Reproduction: towards an Era of Restrictions?

The difficult path towards the recognition of the principle of gender equality also passes through the – still persistent – challenges faced for women to autonomously make decisions over their own bodies and to be fully entitled with the right to self-determination in reproductive choices.

The current and global debate about women's reproductive rights features ongoing tensions around at least two core areas: voluntary termination of pregnancy and access to medically assisted reproductive technologies.

About the former, the safeguard of the right to a free and safe abortion is under pressure within the national scenario as well as globally. Europe, before, with the Polish' Constitutional Court declaration of constitutional illegitimacy of abortion, and the United States, later, with the landmark Supreme Court's judgment on the Dobbs case[13] cast

13. On the Dobbs case, see, *ex plurimis*, R. Kaufman *et al*., *Global impacts of* Dobbs v. Jackson Women's Health Organization *and abortion regression in the United States*, in *Sexual and Reproductive Health Matters*, 2022; A. Baraggia, *La sentenza* Dobbs v. Jackson: *un approdo non del tutto imprevedibile del contenzioso in materia di aborto negli Stati Uniti*, in *BioLaw Journal*, 2023. Furthermore, reference may also be made to M. D'Amico, *Una discussione "maschile" che lascia sullo sfondo le donne e i loro diritti*, in *Associazione italiana dei costituzionalisti*, 2022, where the Author underlined that the *Dobbs v. Jackson Women's Health Organization* decision was the consequence of a broader crisis within contemporary feminist movements. It is argued that the weakening of a collective, transformative vision – one aimed at securing a more just society for all women – has led to a politics focused narrowly on quotas and representation, often benefiting only those already in privileged positions. In this view, the erosion of solidarity and the defensive posture adopted by some feminists in opposing emerging rights (e.g., gender fluidity or surrogacy) reflect a broader failure to maintain a strong, inclusive, and autonomous presence in the public sphere.

more than one doubt on the ongoing accessibility of abortion facilities for women all over the globe.

The gender backlash that influenced and stood behind both these judgements is not confined neither in Poland[14], nor in the United States only. On the contrary, it features several legal systems in Eastern Europe as well, where the opposition against abortion is going hand in hand with that towards the enforcement of the Council of Europe's Convention on violence against women, the so-called Istanbul Convention.

Moreover, with regard to access to abortion facilities, it should be recalled the welcome statement of the European Union, willing to amend the EU Charter on fundamental rights to explicitly guarantee the right to a safe and legal abortion. Same approach has been, this time truly endorsed by France, that decided to include the right to abortion among the rights protected under the French Constitution.

As it will be further explained and emphasized already, discussing about ob-gyn violence means taking into consideration all those practices and conducts that might impair women's reproductive rights.

On this, the Italian legal system represents an emblematic case study with regard to the unfortunate but significant dimension of the phenomenon of objection of conscience, that will be further explored as one of the most significant forms of ob-gyn violence featuring the domestic reality.

The second area where women's reproductive rights are at risk, especially but not only in Italy, is represented by the limited access to

14. Lastly, in October 2020, Poland's Constitutional Court ruled that abortion on the grounds of fetal defects was unconstitutional, effectively resulting in a near-total abortion ban, as such cases accounted for the vast majority of legal terminations. This decision prioritized fetal life despite the Polish Constitution's ambiguous stance on the legal protection of life from conception – a deliberate choice by its drafters. The ruling, which bypassed parliamentary debate on a deeply societal issue, triggered widespread protests and raised serious concerns regarding the impartiality and legitimacy of the Constitutional Court itself. Critics argue that this represents a broader trend of instrumentalizing constitutional mechanisms for political ends, particularly in Poland and Hungary. On this topic, see J. Hussein *et al.*, *Abortion in Poland: politics, progression and regression*, in *Reproductive Health Matter*, 2018; J. Kapelańska-Pręgowska, *The Scales of the European Court of Human Rights*, in *Health and Human Rights Journal*, 2021.

medically assisted procreation technologies. Although, it is less evident the linkage between the restrictions toward assisted reproductive technologies and ob-gyn violence, is, nonetheless, important to recall that the Italian law regulating these technologies, law No. 40 of 2004, represents one of the most restricted law in Europe, with severe consequences on the effective safeguard of the right to health and to self-determination of the women involved.

The perilous features of Italian law on assisted reproductive technologies revolve around the type of legally admitted treatments, as well as the so-called subjective criteria, that cover the identification of who may or may not benefit from to have access to these technologies.

Despite it has been several times brought before the Constitutional Court – including at this very moment with a question of constitutionality pending about the prohibition opposed to single women to access to medically-assisted technologies -, the Italian law continues to negatively affect women's rights and in need to be effectively reconciled with the principles protected under the Italian Constitution.

Beyond objection of conscience to abortion facilities and getting back to the main manifestations of ob-gyn violence featuring the italian legal system, a second phenomenon worth exploring deals with forced sterilization, that, again, constitutes an additional form of ob-gyn violence deserving a separate analysis.

5. Ob-gyn violence in Italy

Besides the limited developments at the supranational level and the legislative responses emerging from the comparative analysis, Italy is not specifically addressing ob-gyn violence[15], despite the progresses made in the most recent years to tackle violence against women.

15. In particular, in Italy the term 'obstetrical violence' was used for the first time in the media campaign promoted by OVO Italia (Observatory on Obstetrical Violence), entitled 'Basta tacere: le madri hanno voce' (Enough silence: mothers have a voice), with the aim of allowing women to recount their experiences of abuse and/or disrespect by health personnel during childbirth. To find out more, see *https://ovoitalia.wordpress.com/*.

Reference is chiefly made to the signature and ratification of the Council of Europe's Istanbul Convention and to the adoption of the first domestic law specifically dedicated to the fight against domestic violence and gender-based violence more broadly, the so-called "Red Code".

The increasing awareness towards the phenomena at stake did not go too far to reach all manifestations of violence against women, especially those featured by the intersection between reproduction and violence.

Italy's legislative framework reveals, in fact, significant gaps in addressing obstetric and gynecological violence.

However, data shows the unceasing impact of ob-gyn violence event in the Italian legal context. Surveys, such as the one conducted by the Observatory on Obstetrical Violence (OVO-Italia), have uncovered alarming levels of abuse during childbirth. For instance, 41% of respondents reported care that compromised their dignity and psychophysical integrity, while 21% experienced direct verbal or physical abuse[16].

Despite these findings, Italy lacks explicit provisions to address obstetric violence, leaving victims without adequate legal recourse.

In 2016, a bill titled *Norme per la tutela dei diritti della partoriente e del neonato e per la promozione del parto fisiologico* (A.C. 3670) was introduced, with the specific aim of promoting the protection and respect of the fundamental rights and dignity of the birthing woman

16. Also, according to a 2016 Doxa survey, one in five women say they have experienced some form of obstetric violence and one in six say they do not want any more children as a result of this experience. The study conducted by Alessandra Bellasio shows that more than 60% of the women interviewed say they have suffered some form of obstetric violence. Many health workers also confirm that they have witnessed similar incidents, although they did not have the courage to report them. The study notes that vegan complaints are almost never made, neither by women nor by health professionals. The feeling, in fact, is that it does not serve anything to do so, precisely because the violence appears systemic and the staff sometimes seems addicted. The answers, however, reveal a significant fact: the figures most sensitive to the subject are those with less years of service. Available at: *https://www.alfemminile.com/genitorialita/violenza-ostetrica-sei-donne-su-dieci-l-hanno-subita/*.

and the newborn, through ensuring the safety of appropriate medical interventions[17].

The proposed bill aimed primarily to guarantee the right of the birthing woman to be adequately informed, with the subsequent possibility of drafting a birth plan that would be binding for the healthcare institution, so that she could freely choose and express her informed consent. The approach behind the bill sought to ensure the protection of the woman's privacy, primarily respecting her free choice, as well as the values of her culture of origin, while requiring that medical and healthcare staff inform the woman adequately, so she could express her freedom in a conscious and informed manner.

The proposal emphasized the need to dismantle the system of degradation and humiliation during childbirth, which often manifested as forms of obstetric violence, imposing the necessity of avoiding the use of offensive expressions or comments about the woman, thus addressing obstetric violence in its linguistic component.

In fact, Article 6 of the so-called *Zaccagnini Bill* stated that "The birthing woman must be treated with respect and dignity and has the right to a positive childbirth experience and to maintain her psycho-physical integrity. It is prohibited to use humiliating or degrading expressions toward the woman during labor, as these are injurious to her personal dignity and dangerous for the childbirth process. It is prohibited for medical and healthcare personnel to make inappropriate comments or remarks about the woman's body […]".

Moreover, the bill defined every form of obstetric violence, which would have been punishable. Article 14 specifically stated that acts of obstetric violence would include: denying appropriate assistance in cases of obstetric emergencies; forcing the woman to give birth in a supine position with raised legs; hindering or preventing early contact between the newborn and the mother without medical justification; hindering or obstructing the physiological process of childbirth through the use of techniques to accelerate labor without the woman's expressed, free, informed, and conscious consent; performing a section without medical indications and without the woman's expressed, free,

17. M. Di Lello Finuoli, *Profili penali della c.d. "violenza ostetrica*, in *Sistema penale*, 2022, 21 ss.

informed, and conscious consent; exposing the woman's body in a way that violates her personal dignity.

Furthermore, the bill introduced a new criminal offense related to obstetric violence, defining as such "the actions or omissions by the doctor, midwife, or paramedical staff that deprive the woman of her autonomy and dignity during childbirth". However, the proposed bill was not voted on.

Although some progress has been made in gender-inclusive medicine – such as the enactment of Law No. 3 of 2018, which promotes a gender perspective in medical research and clinical trials – this has yet to result in specific protections against obstetric or gynecological violence. This results in a significant inconsistency between what the Constitution aims to guarantee and how constitutional principles are translated into legislative measures that can address situations that continue to disproportionately discriminate women.

To better understand how ob-gyn violence reveals itself, the analysis that follows will focus on two emblematic cases: the features and consequences of conscientious objection in abortion services and forced sterilizations.

5.1. The case of conscientious objection in abortion services

In the last century, in Italy as in the rest of the world, women's conquests have been marked by the possibility of deciding autonomously on procreation, both through the birth and use of contraceptive means, and with the progressive recognition of the right to abortion. Motherhood, therefore, has been transformed from a woman's duty, also linked to her role in society, to a free choice, which can also (and predominantly) be made autonomously.

Of course, it was not and is not a linear path and a definitively conquered principle. In Italy, as in the rest of the world, on the 'right' of women to choose with respect to pregnancy, furious ideological battles are still waged today, pitting abstract values, such as life, death, and the family, against concrete situations, such as those faced by women when they decide to terminate a pregnancy.

Over the last thirty years, a further area has emerged in which Law No 194 of 1978 has been instrumentalized for ideological reasons: this is conscientious objection, now invoked in many parts of the country by the majority of doctors, which, precisely because of its broad application, runs the risk of paralyzing the effectiveness of the rules permitting abortion[18].

Indeed, Law No. 194 of 1978, in Article 9, stipulates that healthcare personnel and those performing auxiliary activities are not required to participate in the procedures and interventions for abortion if they raise a conscientious objection, provided they submit a prior declaration. Conscientious objection exempts healthcare personnel and those performing auxiliary activities from carrying out procedures and activities specifically and necessarily aimed at causing abortion but does not apply to activities related to care before or after the intervention. Authorized hospital entities and nursing homes must ensure access to the requested treatment, and regional authorities are required to monitor and ensure the proper organization of these hospitals, including through the mobility of personnel.

In a single case, Law No. 194 stipulates that the right to conscientious objection is overridden by the legal position of the woman. In fact, conscientious objection cannot be exercised when, given the concrete circumstances, the intervention of the doctor, even if they are an objector, is indispensable to save the life of a woman in imminent danger.

18. For an overview of the issues underlying the matter of voluntary termination of pregnancy and conscientious objection, see M. D'Amico, *I diritti contesi. Problematiche attuali del costituzionalismo*, FrancoAngeli, 2016; M. D'Amico, *Donna e aborto nella Germania riunificata*, Giuffrè, 1994; G. Brunelli, *L'interruzione volontaria della gravidanza: come si ostacola l'applicazione di una legge (a contenuto costituzionalmente vincolato)*, in G. Brunelli, A. Pugiotto, P. Veronesi (a cura di), *Scritti in onore di Lorenza Carlassare*, Editoriale Scientifica, 2009; A. Pugiotto, *Obiezione di coscienza nel Diritto costituzionale*, in *Digesto delle discipline pubblicistiche*, 1992; B. Randazzo, *Obiezione di coscienza (diritto costituzionale)*, in S. Cassese (a cura di), *Dizionario di diritto pubblico*, Giuffré, 2006; F. Grandi, *Doveri costituzionali e obiezione di coscienza*, Editoriale Scientifica, 2014.

In light of these provisions in Article 9, there have been multiple attempts to extend their scope of application. In particular, the fact that there has been a high and continually increasing number of conscientious objector doctors, who, despite the lack of hospital organization and regional provisions, have effectively hindered women's right to access the requested treatment under the conditions stipulated by Law No. 194, has become a prominent issue. The mass and "reckless" use of conscientious objection by doctors can not only compromise the woman's position (and therefore her right to access the requested service, as prescribed by Law No. 194) but also the position of non-objector doctors, who are forced to face the overall workload arising from the high and increasing number of conscientious objectors and the corresponding disorganization of hospitals and regional authorities.

The issues surrounding the difficulties pregnant women face in accessing abortion services have never been brought before the Constitutional Court, possibly due to the practical difficulties encountered by women in such situations. Consider, first, the requirement to comply with the time limitations imposed by Law No. 194 for accessing abortion services. The difficulties in accessing the service mean that women must travel to another facility within the same city, within the same region, to another region, or even to another country.

Consider also the concrete difficulties faced by non-objector doctors, who suffer negative professional consequences from the type of service they provide continuously. This issue assumes particular relevance in light of the procedures initiated before the European Committee of Social Rights of the Council of Europe[19]. In the case of an initial Complaint, the Committee found a violation of women's rights under the European Social Charter, specifically in situations where access to abortion is either denied or hindered. In relation to the second collective complaint, the Committee not only confirmed the continued violation of these rights but also acknowledged the violation of the rights of non-objector doctors.

19. M. D'Amico, G. Guiglia (edited by), *European Social Charter and the challenges of the XXI century. La Charte Sociale Européenne et les défis du XXIe siècle*, Editoriale Scientificca, 2014.

In its decision regarding Collective Complaint No. 87 of 2012[20], filed by the International Planned Parenthood Federation European Network, the European Committee recognized that Italy does not guarantee, as required by Article 9 of Law No. 194, access to abortion services. This failure to guarantee access constitutes a direct violation of the right to health for women (Article 11 of the European Social Charter), which is functionally linked to access to abortion, and the principle of non-discrimination (Article E of the European Social Charter), as it results in unreasonable discrimination between categories of women based on territorial and economic factors[21].

Following the decision on the merits in relation to this first collective complaint, the Committee of Ministers of the Council of Europe issued a Resolution (April 30, 2014), acknowledging the same findings and calling for the adoption of specific measures – those deemed appropriate by the Italian legal system – to address the identified issues.

The Minister of Health, in October 2014 and again in October 2015, presented the first results of the Monitoring Table established to map the situation and actual practices concerning conscientious objection in this matter. In the annual Report to Parliament on the state of implementation of Law No. 194, the Minister reiterated that there were no issues with the guarantee of the service.

20. For a comment, M. D'Amico, *The Decision of the European Committee of Social Rights on the conscientious objection in case of voluntary termination of pregnancy (Collective Complaint No. 87/2012)*, in M. D'Amico, G. Guiglia (edited by), *European Social Charter and the challenges of the XXI century*, cit., 219.

21. In particular, the European Committee of Social Rights, in its decision on Complaint No. 87/2012 (IPPF EN v. Italy), identified a case of intersectional discrimination affecting women seeking access to lawful abortion services. The Committee held that impediments to such access – arising from the combined impact of territorial disparities, socio-economic disadvantage, health status, and gender – amounted to a form of 'multiple' or 'overlapping' discrimination. These barriers, aggravated by the widespread use of conscientious objection among healthcare personnel and the lack of adequate compensatory measures by the authorities, result in unequal and less favourable treatment of certain vulnerable categories of women.

With respect to the second collective complaint, filed by the Italian General Confederation of Labour (CGIL) (No. 91 of 2013)[22], the European Committee of Social Rights, after accepting the Italian government's request to hold a public hearing on September 7, 2015, at the European Court of Human Rights, reiterated that the violation of Articles 11 and E of the European Social Charter had not been resolved. Moreover, it found that the rights of non-objector doctors were also being violated. Following the decision on this second complaint, the European Committee of Social Rights once again invited Italy to adopt concrete measures to end the violations of both women's and doctors' rights, as determined by the Committee itself[23].

22. For further commentary, see B. Liberali, *Le problematiche applicative della legge n. 194 del 1978 relative al diritto di obiezione di coscienza ancora a giudizio (Prime osservazioni alla decisione del Comitato Europe dei Diritti Sociali nel caso CGIL contro Italia)*, in *BioLaw Journal*, n. 2, 2016. The Committee held that barriers to abortion access – arising from the widespread use of conscientious objection by medical staff and inadequate health system organization – disproportionately harm women based on a combination of gender, health status, geographic location, socio-economic conditions, and, in some cases, immigration status. These factors, taken together, result in less favorable treatment compared to individuals seeking other medical services, thus constituting a violation of the non-discrimination clause under Article E of the European Social Charter.

23. Following the two decisions issued by the European Committee of Social, certain hospitals have undertaken measures to implement Article 9 of Law No. 194/1978. This provision requires that healthcare institutions, under the supervision of regional authorities, be organized in such a way as to guarantee access to abortion services, without impairing the lawful exercise of conscientious objection. Notable among such measures are the public recruitment notices issued by hospitals such as the San Camillo Forlanini and Policlinico Umberto I in Rome, and the Pugliese Ciaccio Hospital in Catanzaro, all of which explicitly sought medical personnel willing to perform terminations of pregnancy and, hence, not to invoke conscientious objection. These notices neither resulted in the dismissal of objecting physicians nor required the revocation of their conscientious objection status; rather, they were aimed at identifying professionals willing to perform procedures that other medical staff lawfully refused to carry out. Far from creating a discriminatory distinction among physicians, these initiatives not only operationalize Article 9 but also align with the Committee's recommendations and the subsequent Resolutions of the Committee of Ministers of the Council of

It should also be emphasized that this situation, acknowledged at the supranational level, may constitute a violation of the first paragraph of Article 117 of the Italian Constitution, precisely in relation to the constitutional parameter provided by the European Social Charter, which requires national and regional lawmakers to respect international obligations, in this case arising from the European Social Charter itself.

5.2. The case of forced sterilizations

The link between women's rights and reproductive rights is closely connected to the issue of personal autonomy and dignity.

From this perspective, an additional area of concern within the domain of procreative choices pertains to forced sterilizations[24].

Forced sterilization, particularly of women with disabilities, is an underreported but persistent violation of women's rights in Italy.

Despite international human rights treaties prohibiting the practice, it remains largely unregulated within Italian law. This legislative silence

Europe, which urged Italy to remedy its ongoing violation of the European Social Charter. Moreover, in light of the European Court of Human Rights' jurisprudence, these recruitment policies do not appear to infringe upon Convention rights, since the Court has recognized that the freedom to manifest one's conscience or religion does not entitle a healthcare professional to claim discrimination when excluded from a role that inherently requires the performance of duties they refuse to carry out. To learn more, refer to B. Liberali, *Obiezione di coscienza nell'interruzione di gravidanza ancora a giudizio? Punti fermi e prospettive future*, in *BioLaw Journal*, n. 3, 2020, 353 ss.

24. For a broader framework on this topic, see C. Zampas, A. Lamačková, *Forced and coerced sterilization of women in Europe*, in *International Journal of Gynecology & Obstetrics*, 2011; D. Alaattinoğlu, *Forced sterilisation in the Istanbul Convention. Remedies, intersectional discrimination and cis-exclusiveness*, London, 2020; P. Patel, *Forced sterilization of women as discrimination*, in *Public Health Rev*, 2017, which underlines that medical personnel have historically justified coerced and forced sterilizations as measures necessary for public health. In the early 20th century, these practices were framed as solutions to hereditary and genetic "defects", while in the late 20th century, they were promoted as responses to concerns about overpopulation.

enables practices that deprive women of their autonomy, reinforcing systemic discrimination against marginalized groups.

Article 39 of the Istanbul Convention defines forced sterilization as "a surgical procedure aimed at and resulting in the permanent disruption of a woman's reproductive capacity without her prior informed consent or understanding of the procedure being performed", urging the Parties to adopt legislative or other necessary measures to criminally pursue such "intentional" practices.

Thus, this process is considered forced when a person is subjected to sterilization without their knowledge, consent, or after explicitly refusing it; it is coercive when the person is compelled to accept sterilization by their family and/or medical professionals. From a medical perspective, one of the most common forms of forced sterilization involves the obstruction of the fallopian tubes, which anatomically connect the ovaries to the uterus. Through ligation, the migration of the egg from the tube and the ascent of sperm towards the tube are permanently blocked, preventing fertilization[25]: unlike forced abortion, this practice aims to permanently disrupt a woman's reproductive capacity.

Although historically considered a form of birth control[26], Although historically allowed to some extent as a form of birth control – and, as we will see, still occurring today – forced sterilizations represent a form of gender-based violence, understood as an expression of an unequal power hierarchy, still deeply rooted in stereotypes about a woman's role and her ability to self-determine.

Thus, forced sterilization can be considered a specific manifestation of the broader phenomenon of obstetric violence, as it directly violates a woman's reproductive rights. It is useful to recall the Venezuelan *Ley Orgánica*, which, in Article 15, includes such practices – for the first time on the international stage – under the broader concept of violence,

25. D. Corea, *Sterilizzazione tubarica*, in *https://www.aogoi.it*.; Comitato Nazionale di Bioetica, *Il problema bioetico della sterilizzazione non volontaria*, 20 novembre 1998, in *https://bioetica.governo.it.*

26. Cfr. V. Tevere, *La sterilizzazione forzata delle donne come forma di violenza di genere: un'analisi "intersezionale"*, in A. Di Stati, R. Cadin, A. Iermano, V. Zambrano (a cura di), *Donne migranti e violenza di genere nel contesto giuridico internazionale ed europeo*, Editoriale Scientifica, 2023, 341 ss.

defined as the "appropriation of a woman's body and reproductive processes by health personnel, expressed through inhumane treatment, the abuse of medicalization, and the pathologization of natural processes, leading to the loss of autonomy and the ability to freely decide about her own body and sexuality, negatively impacting the quality of life of the woman".

The World Health Organization has also classified forced sterilizations among abusive healthcare practices during childbirth, noting that such abuses are more frequently carried out against the most vulnerable women, those in disadvantaged socio-economic situations, as well as women belonging to ethnic minorities, migrant women, women living with HIV, and women with disabilities[27].

On the normative level, forced sterilization holds international significance as it is considered a violation of human rights, including dignity, physical integrity, privacy, and the right to free and informed consent. Article 7 of the Rome Statute of the International Criminal Court includes forced sterilizations in the list of acts that constitute crimes against humanity.

As a practice most prevalent among people with disabilities, one of the main sources of legislation prohibiting such practices is the 2006 United Nations Convention on the Rights of Persons with Disabilities, which contains several relevant provisions. Among these are Article 12, which affirms the right of persons with disabilities to equal recognition before the law and to enjoy legal capacity on an equal basis with others, as well as the right to receive support to exercise their legal capacity; Article 16, which reminds States to protect persons with disabilities

27. OHCHR, UNWOMEN, UNAIDS, UNPD, UNFPA, UNICEF, WHO, *Eliminating forced, coercive and otherwise involuntary sterilization. An interagency statement*, 2014. On this, see, also, G. Arconzo, *La violenza nei confronti delle donne con disabilità*, in M. D'Amico, C. Nardocci, S. Bissaro (a cura di), *Le violenze contro la donna. Origini, forme, strumenti di prevenzione e repressione della violenza di genere*, FrancoAngeli, 2023; S. Carnovali, *Il corpo delle donne con disabilità. Analisi giuridica intersezionale su violenza, sessualità e diritti riproduttivi*, Aracne, 2018; G.B. Robertson, *Sterilization, Mental Disability, and Re Eve: AffirmativeDiscrimination?*, in W.S. Tarnopolsky *et al.* (edited by), *Discrimination in the Law and the Administration of Justice*, Les Éditions Thémis, 1993.

from all forms of violence and abuse, adopting all legislative, social, and educational measures for this purpose; Article 17, which protects the physical and mental integrity of persons; Article 23, which enshrines the right to form a family and to "decide freely and responsibly on the number and spacing of children", as well as to access information on procreation and family planning; and finally, the right to free and informed consent in the field of health, as guaranteed by Article 25.

Equally significant, from the perspective of legal sources, is the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which urges signatory States to take all necessary measures to prevent discrimination against women in healthcare and to ensure access to health services.

Within the European regional framework, the Strasbourg Court has, on several occasions, framed gender-based violence within the context of Articles 3 (prohibition of inhuman and degrading treatment) and 8 (respect for private and family life) of the European Convention on Human Rights (ECHR)[28].

Also notable is the 1997 Council of Europe Convention of Oviedo for the protection of human rights and the dignity of the human being, which safeguards human dignity, rights, and freedoms against any abuse of advancements in biology and medicine, establishing the principles of personal integrity and the primacy of the human being.

Forced sterilization is authorized by the legislation of 14 European Union member states. As for Italy, while forced sterilization of people with disabilities is not permitted, it does provide exceptions, particularly in cases where such a practice is considered an urgent or therapeutic measure[29].

28. In this sense, European Court of Human Rights, judgment of 25 September 1997, no. 57/1996/676/866, *Aydin v. Turkey*; European Court of Human Rights, judgment of 4 December 2003, no. 39272/98, *MC v. Bulgaria*; European Court of Human Rights, judgment of 8 November 2011, no. 18968/07, *V.C. v. Slovakia*.

European Court of Human Rights, judgment of 12 June 2012, no. 29518/10, *N.B. v. Slovakia*; European Court of Human Rights, judgment of 20 September 2022, *Y.P. v. RussiaI*.

29. European Disability Forum, *Sterilizzazione forzata delle persone con disabilità nell'Unione Europea*, September 2022, in *https://informareunh.it/wp-content/uploads/EDF-rapporto-edf-sterilizzazione-forzata-2022.pdf*.

As previously mentioned, the Istanbul Convention includes forced sterilization among the forms of gender-based violence, recognizing it as a violation of women's reproductive rights and placing an obligation on States to criminalize such acts. In Italy, however, there is no specific criminal offense related to forced sterilizations, although the specific crime of forced abortion could be considered under Article 18 of Law No. 194 of 1978. Aside from this, forced sterilizations can be prosecuted as an aggravated form of bodily injury under Article 583, paragraph 1, of the Penal Code, which stipulates that "whoever intentionally causes personal injury that results in the loss of the ability to procreate shall be punished with imprisonment from 6 to 12 years".

However, according to the latest GREVIO report, the committee of experts monitoring the "implementation status" of the Istanbul Convention, Italy shows a lack of significant jurisprudence on this matter. For GREVIO, this suggests that cases of forced sterilizations tend to be concealed, often hidden behind requests from family members and medical justifications such as biopsies or endoscopies[30].

6. Concluding Remarks

Obstetric and gynecological violence represents a profound violation of women's rights, deeply rooted in the systemic, cultural, and historical biases that have long marginalized women's rights and autonomy in healthcare.

The practices that constitute ob-gyn violence, from verbal and physical abuse to the disregard for women's informed consent to medical treatments, are not just individualized violations, but the result of entrenched patriarchal structures within medical systems worldwide. The conducts that we have here defined as forms of ob-gyn violence profoundly undermine women's trust in the healthcare, perpetuate

30. GREVIO, *Rapporto di valutazione (di base) sulle misure legislative e di altra natura da adottare per dare efficacia alle disposizioni della Convenzione del Consiglio d'Europa sulla prevenzione e la lotta contro la violenza nei confronti delle donne e la violenza domestica sull'Italia*, 13 gennaio 2020, 1-92 (*https://www.coe.int/en/web/istanbul-convention/home*). Italian Version.

gender inequality, and inflict long-lasting physical and psychological harm on women, with far-reaching consequences for their well-being and active engagement and participation in the society.

The legislative responses to ob-gyn violence remain uneven and insufficient.

Venezuela's pioneering legislation offers a model for recognizing and combating the issue, highlighting the systemic nature of the problem and its impact on women's dignity and autonomy. The same has to say for Mexico and Argentina, which, despite their pioneering move towards the strengthening of women's rights, remain isolated in the Latin and South American context.

Italy, despite strides in gender-inclusive medicine, illustrates the challenges of addressing ob-gyn violence within a fragmented legal framework that fails to provide specific protections to women when it comes to their bodies and the safeguard of the principle of self-determination.

The emblematic cases of the challenges featuring the law on medically-assisted procreation and voluntary termination of pregnancy represents a crystal-clear demonstration of the long way ahead before women's self-determination in reproductive choices will be effectively safeguarded.

Critical issues such as forced sterilization and the misuse of conscientious objection in the context of voluntary termination of pregnancy further exacerbate the vulnerabilities of women, particularly those belonging to marginalized groups, exposing the gaps in safeguarding reproductive rights and accessing to medical treatment and healthcare.

Moving forward, a comprehensive approach is essential and much needed. This includes the development of targeted legal frameworks to define and address ob-gyn violence, aligned with international human rights standards.

Equally important will be to foster cultural change within healthcare institutions to prioritize respect, empathy, and the active inclusion of women in all the decisions impacting on their bodies and psychological well-being.

The recent law enacted by Portugal in 2025, first Country in Europe following the preliminary experiment set under the law adopted by

Catalunya (Spain), defines ob-gyn violence as any conduct performed by midwives and medical doctors, be it physical or verbal, against women and their bodies during pregnancy and labour. Despite the ground-breaking effect of the law, which brings Europe back at the center of the debate joining South America in the fight against ob-gyn violence, critics highlights that the law does not cover additional manifestations of ob-gyn violence, especially those impacting on the psychological and emotional well-being of women.

Eventually, and unfortunately, Italy does not depart from the status quo. A status quo made of lack of protection that leaves women alone in some of the most crucial moments of their existence.

By confronting all these challenges head-on, the hope is that societies will move closer at the global level to ensure that reproductive healthcare becomes not only accessible to women, but, most importantly, respectful of their human dignity, autonomy, and fundamental rights.

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Gender Health Gap. Health, Maternity and Obstetric Violence

Francesca Rescigno

Summary: 1. *Gender health gap*. Women's health beyond the reproductive sphere – 2. Motherhood between social value and obstetric violence.

1. *Gender health gap*. Women's health beyond the reproductive sphere

Health is a complex good, and the attainment of a good state of health is not achieved by the mere absence of disease and infirmity, but it is necessary to ensure the subject's effective capacity for self-management and self-determination of his or her own psycho-physical state, and in this sense health is among the instruments of personal empowerment.

The survey of women's health highlights a very peculiar situation since medical science has always tried to flatten the existing differences between women and men in an attempt to build a single reference model. This process of 'health neutralization' has met with the sole exception of sexuality and reproductive organs, an area in which women and men have been considered from the outset as profoundly different and in need of a differentiated medical-scientific (but also legal) approach[1] . The health 'false neutral' has caused a bias

1. For a more extensive reconstruction, allow me to refer to my F. Rescigno,

against women's health because health is not a sexually indifferent concept since it is connected to the different physical and biological characteristics of women and men with which gender differences are also associated. These obvious dissimilarities reverberate on the health status of women and men who, when affected by the same diseases, often experience dissimilar symptoms and react differently to the same treatments. The attainment and maintenance of good health is conditioned by so-called 'determinants of health' including personal behaviors and lifestyles, social factors, working conditions, accessibility to health services, general socio-economic, cultural and environmental conditions and, of course, genetic factors[2] . Emblematic is the circumstance whereby, among the negative determinants of health, membership in the female sex is included: in fact, there is a negative health *gap* related to the traditional economic-social and labor subordination of women, but included to the false neutral paradigm elaborated by medical science. Being born a woman, therefore, at any latitude and with any economic-social-cultural condition, constitutes, even today, a negative determinant of health and so alongside the *gender pay gap* we can also consider the *gender health gap*.

There is one area in which woman and man have always been considered as 'different bodies', and that is the field of reproduction. Since ancient times, in fact, the attention of early medical studies to women, otherwise ignored, has focused precisely on their reproductive capacity in order to know, investigate and perhaps control it. Studies of the female body focused, at least until the 1990s of the last century, almost solely on reproductive function and sexual organs, giving rise to what is referred to as the 'bikini syndrome', in the sense that a specificity of the female body is recognized only

Per un habeas corpus "di genere". Health, female self-determination, sex and gender medicine, Editoriale Scientifica, 2022.

2. On these determinants see WHO - Commission on Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health*, Final report of the commission on social determinants of health, Geneva, 2008.

with reference to sexual characters. Motherhood, and next to it the tasks of care, have always been traced back to the female universe alone, and it was necessary to wait for the advent of the first feminist movements for this assumption to be challenged and the link between the female condition and the gender-based division of labor to show its load of ambiguity, as well as to recognize the simultaneously liberating and oppressive character of motherhood itself[3] .

Since the end of the nineteenth century, women have been on a path of liberation, which especially since the second half of the twentieth century has also involved the management of the body and health, in order to assert a new female position within society, politics, the world of work and the cultural world. Even today the first twenty years of the twenty-first century having passed, this path does not yet appear to have come to a conclusion, and the 'uterine woman' still very often inhabits contemporary language.

2. Motherhood between social value and obstetric violence

The substantial disregard of medical science for women's specificity with the exception of reproductive health has led women to focus particularly on the management of their own sexuality and motherhood in order to assert their self-determining capacity in this regard. Thus, the path to equality beyond gender is accomplished not only through political, economic and social achievements, but also, or perhaps first and foremost, through the affirmation of female self-determination with respect to sexuality and motherhood, too long investigated and legislated as something abstract and separate from the one who is a mother, while only the woman possesses that gender specificity that allows her (if she so desires) to become a dual unit, characterized by a special relationship with the unborn[4].

3. See A. Scattigno, *La figura materna tra emancipazione e femminismo*, in M. D'Amelia (a cura di), *Storia della maternità*, Laterza, 1997, 273.

4. As Sofri notes, "*Mother and unborn child are, in an otherwise unthinkable way, two and one. Without this admission, habeas corpus does not exist, except as the right of males for males*" (translation by author of contribution). See A. Sofri, *Contro Giuliano. Noi uomini, le donne e l'aborto*, Sellerio, 2008, 27.

Motherhood, in addition to its purely health aspect, has an important legal content related to its 'social value'; the Italian Constitutional Charter itself deals with motherhood and mothers, affirming the Republic's commitment to ensuring support and adequate protection for the family, motherhood and childhood. The favor toward motherhood expressed in the second paragraph of Article 31 should be read in conjunction with the first paragraph of Article 37, which protects the working mother by giving her an 'essential family function'. Words are important, and when the Constitution speaks about 'fulfillment', there is a strong reference to a real 'obligation', just as the adjective 'essential' seems to imply that it is impossible to free oneself from the primary function attributed to women, a family function that refers not exclusively to what only women can do, that is, the physical production of children, but to all care tasks that have always been attributed 'to the angels of the hearth'. Indeed, an effort should be made to put into context the time when this provision was passed, in order to understand the desire to realize a project of social transformation aimed at changing the position of the working woman (mother), creating an ascending process of inclusion toward equality[5] . A path clearly not yet accomplished[6] .

Recognizing the social value of motherhood, as pointed out by Lina Merlin, "does not only affect the woman, or the man, or the family; it affects the whole society. Protecting the mother means protecting society at its root"[7].

5. See the exhaustive reconstruction by E. Catelani, *La donna lavoratrice nella "sua essenziale funzione familiare" a settant'anni dall'approvazione dell'art. 37 Cost.*, in *Federalismi.it*, special issue 5/2019, 66.

6. It is enough to view the *Global Gender Gap* Index compiled annually by the *World Economic Forum*, an index that measures the evolution of gender equality in four key areas: economic participation and opportunity, educational attainment, health and survival, and political empowerment. Italy, which in 2023 was ranked 79th out of 146 countries (thus not particularly advanced), drops to 87th position in 2024 with a result that highlights the historical and cultural problem that our country continues to have with respect to achieving gender equality. See *https://www.weforum.org/publications/global-gender-gap-report-2024/*.

7. See A.C. III Subcommittee September 13, 1946, at *https://www.nascitacostituzione.it/02p1/03t3/037/index.htm*.

The 'social value of motherhood' must therefore be read under the lens of the principle of equality, whereby being a mother is no longer (and probably never has been) the main task of women, but, at the same time, it is also true that many working women are also mothers, so the Republic must consider how motherhood, or even better parenthood, can be reconciled with the needs of working men and women[8] .

The importance of motherhood, not only as a choice associated with women's health but also in its social and constitutional value, could lead to the assumption that every moment connected with pregnancy and birth is protected and safeguarded in order to preserve the psycho-physical health of the mother and the unborn child[9]. Unfortunately, this assumption is very often disavowed by facts, and thus both gestation and childbirth can turn into acts of violence against women.

"I will multiply your sorrows and your pregnancies, in sorrow you will bear children" this is the anathema issued by God to Eve after she ate the apple of knowledge in the Garden of Eden[10], so from that moment on, women of all times are condemned to suffer the pain of childbirth without being entitled to complain. The Judeo-Christian tradition has always paid special attention to the maternal function as an element of identity for women, worthy as mothers, cursed and repudiated if infertile. In the last century, however, motherhood has been characterized by a decisive shift in perspective, moving from a biological function suffered and imposed on women to give them a role in society to a free and conscious choice that disavows the

8. There is no denying how, even today, the family burden continues to weigh mainly on women, who often find it difficult to reconcile family and work. A recent ISTAT survey showed that in the second quarter of 2023, the employment rate of 25-49 year olds is 81.3 percent if the woman lives alone, drops to 76.2 percent if she lives as a couple without children and 60.2 percent if she has children (*https://www.istat.it/it/files//2024/04/3.pdf*).

9. On some of the contradictions of motherhood, see F. Rescigno, *Lemma Maternity*, in L. Pupilli, M. Severini (a cura di), *Ventuno parole. Lemmario di storia e vita femminile nella contemporaneità*, Millesettecentonovantasette Edizioni, 2024, 57.

10. Cf. *Genesis* 3:16-19.

hierarchical-patriarchal structure of the family system and the merely generative function of women, constructing a new interpretation of the world from the 'symbolic power' of the generative function itself: a function of growth and mediation that characterizes the female universe[11].

The moment of childbirth still appears today cloaked in substantial discretion and in the collective imagination corresponds to a happy and delicate parenthesis experienced by mother and child in complete serenity. Unfortunately, this idyllic picture does not always correspond to reality, and women are very often subjected to real physical and psychological violence, as if the current health care systems felt obliged to concretize the words of Genesis: this is what we call 'obstetric violence'.

Obstetric violence refers to harmful behaviors inflicted on women during pregnancy, childbirth, and also in the postpartum period. This type of violence can be both interpersonal and structural, i.e., resulting from the actions of health professionals, but also from policies that penalize women, which is why obstetric violence is often linked to situations of strong inequality and discrimination.

In April 1985, the World Health Organization (WHO) and the Pan American Health Organization (PAHO) sponsored an interdisciplinary conference on Appropriate Technology for Birth by adopting a set of recommendations entitled 'Appropriate Technology for Birth', including the woman's right to exercise control over the conditions of labor and delivery, the importance of communication between women, their families and health personnel. This document does not explicitly mention 'violence' but focuses on 'disrespect and mistreatment during childbirth' which can be physical or psychological[12] .

Eleven years later, in 1996, WHO returned to the 'birth issue' with the publication of the guide 'Cuidados en el Parto Normal: guía práctica'[13] where it reiterates and expands previous recommendations,

11. Thus L. Muraro, *L'ordine simbolico della madre*, 2ª ed., Editori Riuniti, 2006.

12. See *Appropriate technology for birth*, in *Lancet*, August 24,1985, 2(8452):436-7.

13. *https://www.index-f.com/lascasas/documentos/lc0063.pdf*.

including avoiding episiotomy[14], amniotomy[15] and especially the Kristeller maneuver, which can cause damage to the uterus, perineum and fetus and whose validity is not scientifically proven[16] .

But it was in 2014 that WHO took an even more precise position by publishing the Declaration on "The Prevention and Elimination of Disrespect and Abuse during Labor and Childbirth in Health Facilities", in which it highlighted the prevalence of abusive phenomena related to childbirth[17]. Thus, while the increase in maternity care at health facilities is to be welcomed, it becomes imperative to ensure respectful and non-abusive treatment of women's decision-making capacity and dignity. The behaviors stigmatized by the Declaration include: direct physical abuse, humiliation, verbal abuse, the implementation of coercive or unconsented medical procedures, all maneuvers and interventions that are not actually necessary or are performed without consent or without even simple information, up to sterilizations; still the lack of confidentiality, the refusal to offer adequate pain therapy, violations of privacy, and neglect in childbirth care that often leads to otherwise avoidable complications are configured as violence. These behaviors appear serious and unjustifiable because, as WHO recalls, "every woman has the right to the highest possible standard of health, which includes the right to decent and respectful care during pregnancy and childbirth, as well as the right to be free from violence and discrimination. Abuse, neglect or disrespect during childbirth can

14. Episiotomy, also known as perineotomy, is a surgical procedure that involves an incision in the patient's perineum during the expulsive phase of childbirth.

15. This is the intentional rupture of fetal membranes by health care personnel to hasten the birth of the baby.

16. The Kristeller maneuver involves applying manual pressure to the uterine fundus during maternal contraction and pushing, in the direction of the birth canal with the aim of reducing the duration of the second stage of labor. There isn't a single, universally standardized definition of this maneuver, and the ways in which pressure is applied can vary. Although there is little scientific evidence for it, it is a traumatic procedure still widely used in delivery rooms around the world.

17. See *https://iris.who.int/bitstream/handle/10665/134588/WHO_RHR_14.23_ita.pdf*.

lead to the violation of women's fundamental human rights as described in internationally adopted human rights norms and principles"[18].

In 2019, the Council of Europe passed Resolution No. 2306/2019, which qualifies obstetric and gynecological violence as a real form of violence against women by placing it within the normative framework of the Istanbul Convention, concluded in 2011[19]. The document defines the phenomenon by stating, "Obstetric and gynecological violence is a form of violence that has remained hidden for a long time and is still often ignored. In the private setting of medical consultation or during childbirth, women are victims of violent practices or what may be perceived as such-including inappropriate and unconsented acts, such as episiotomies and vaginal palpations performed without consent, pressure on the bottom of the uterus, or painful interventions performed without anesthesia. Sexist behavior during medical

18. The *Committee on the Elimination of Discrimination against Women,* which monitors the implementation of the 1979 *Convention on the Elimination of all forms of Discrimination Against Women* (CEDAW), has also addressed obstetric violence in some recent individual Communications. Communication 138/2018 stigmatized behaviors such as unnecessary vaginal examinations, administering oxytocin and performing an episiotomy without information or consent, acts that violate women's rights (see CEDAW Committee Dec. U.N. Doc. CEDAW/C/75/D/138/2018). In Communication 149/2019, it was pointed out that early induction of labor by oxytocin without providing information or seeking consent, inability to eat, infantilization, performing a cesarean section without consent, separation from the child, along with the imposition of artificial feeding contrary to parental advice, all represent forms of obstetric violence (see CEDAW Committee Dec. U.N. Doc. CEDAW/C/82/D/149/2019). And finally, Communication 154/2020 states that loss of dignity, abuse and mistreatment, as well as the irregular use of epidural anesthesia without obtaining informed consent and without having justified the need for it, as well as the failure to obtain informed consent before performing a cesarean section, constitute obstetric violence. Finally, the Committee recalls that States Parties to CEDAW must comply with their obligation to take all appropriate measures to amend and eliminate regulations, practices and customs that may reiterate forms of discrimination against women (see CEDAW Committee Dec. U.N. Doc. CEDAW/C/84/D/154/2020).

19. See *Council Recommendation 2009/C 151/01 on patient safety, including the prevention and control of healthcare associated infections. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX- :32009H0703(01).*

examinations has also been reported". The Assembly calls on Member States and Ministries of Health to produce data on obstetric and gynecological violence, make them public, and promote respectful maternity care as proposed by WHO. It is necessary, with a view to the humanization of birth, to introduce issues related to obstetric violence into the training of physicians and health personnel, along with relational aspects, informed consent, respect for diversity, and prevention of sexist phenomena.

In 2021, the European Parliament approved a text on Sexual and Reproductive Health and Related Rights in the EU under Women's Health, which states: "There is a lack of substantive data on the issue of obstetric violence against racialized women in Europe; that such discrimination leads to higher rates of maternal mortality and morbidity (among black women, for example), higher risk of abuse and violence (for women with disabilities), lack of access to information, and general injustice and inequality in access to services concerning sexual and reproductive health and related rights"[20].

Obstetric-gynecological violence is therefore a true form of violence and as such should also be identified and stigmatized through appropriate regulatory interventions; however, despite the international references already highlighted, at present very few countries have regulated this case, in particular it is the Latin American area that has specific regulatory provisions on the subject[21], while within the

20. See *https://www.europarl.europa.eu/doceo/document/TA-9-2021-0314_IT.pdf*.

21. These are Venezuela which, first, in 2007 enacted the *Ley Organica sobre el derecho de las mujeres a una vida libre de violencia*; Argentina with Ley no. 25.929, *Parto Humanizado*, 25 de agosto de 2004 ed la *Ley de Proteccion Integral a las mujeres*, of 2009; of some Mexican states and the Central State itself (*Ley Nacional General de Acceso de las mujeres a una vida libre de violencia*, 2007); Estado de Guanajuato, *Ley de Acceso de las Mujeres a una Vida Libre de violencia*, 2015; Estado de Colima, *Ley de Acceso de las Mujeres a una Vida Libre de violencia,* 2016; Estato de Hidalgo, *Ley de Acceso de las Mujeres a una Vida Libre de violencia*, 2016; Uruguay with Ley no. 17,386, *Ley de acompañamiento de persona de su confianza durante el parto*, 2001; and of the State of Santa Catarina in Brazil with the Ley, *Dispõe sobre a implantação de medidas de informação e proteção à gestante e parturiente contra a violência obstétrica no Estado de Santa Catarina*, 2017. In 2016, on the other hand, the State of Puerto Rico amended its 2006

European Union only Portugal has recently passed a specific law on obstetric violence. This is Law No. 33 of 31 March 2025 entitled: 'Promove os direitos na gravidez e no parto e altera a Lei n.º 15/2014, de 21 de março', which aims to promote rights in the pre-conception phase, in medically assisted procreation, during pregnancy, at the time of childbirth, through the creation of information and protection measures against obstetric violence and the establishment of a multidisciplinary commission for rights during pregnancy and childbirth.

The law uses the definition of 'obstetric violence' stating, in Article 2, that this term refers to any 'physical and verbal action exercised by healthcare professionals on the body and procedures in the reproductive area of women or other pregnant persons, which is expressed in inhuman treatment, abuse of medicalisation or the pathologisation of natural processes, not respecting the regime of protection in pre-conception, medically assisted procreation, pregnancy, childbirth, birth and the postpartum period'.

The attention paid by the law to specific obligations in the field of education and training is particularly important. Firstly, the Ministry of Education is responsible for including, in the content of sex education programmes, information appropriate to different school levels on obstetric violence, in order to promote respect for sexual and reproductive autonomy and contribute to the elimination of gender-

law "*Ley de Acompañamiento durante el Trabajo de Parto, Nacimiento y Post-parto*", where it emphasizes the need to enhance the decision-making capacity of women, who should be duly and preliminarily informed of any procedure that might be undertaken (*https://bvirtualogp.pr.gov/ogp/Bvirtual/leyesreferencia/PDF/Familia/156-2006.pdf*). It should also be noted that the Inter-American Court of Human Rights, in the case *Brítez Arce y otros vs. Argentina*, defined obstetric violence as "*a form of gender-based violence [...] exercised by health professionals against pregnant women, during access to health services that take place during pregnancy, childbirth and postpartum, which is expressed mainly, but not exclusively, in dehumanizing, disrespectful, abusive or negligent treatment of pregnant women; in the denial of care and full information about the state of health and applicable treatments; in forced or coercive medical interventions...*". See Inter-American Court of Human Rights, *Brítez Arce y otros Vs. Argentina* case, Judgment of November 16, 2022. *https://www.corteidh.or.cr/docs/casos/articulos/seriec_474_esp.pdf*.

based violence (Article 3). Secondly, higher education institutions providing training in health and social policies are required to include in their curricula and training programmes content on human rights, aimed at ensuring respect for sexual and reproductive autonomy and raising awareness of practices that constitute forms of obstetric violence (Article 4).

The approval of the Portuguese law is a response to a serious phenomenon that must be addressed in a multidisciplinary manner, and will hopefully have a positive influence on other Member States.In some member states, including Italy, draft laws are under discussion[22], but so far there are only a few virtuous examples at the local level, such as the measure approved by Catalonia that explicitly includes obstetric violence and the violation of sexual and reproductive rights within the scope of gender-based violence[23] . Law No. 1 of 2022 of the Autonomous Community of the Basque Country, on equality between women and men, also mentions obstetric violence among the forms of violence; while Health Law No. 10 of 2014 of the Community of

22. See Bill No. 3670 on the initiative of Congressman Zaccagnini, submitted to the Chamber of Deputies in March 2016, containing Norms for the protection of the rights of the parturient and the newborn and for the promotion of physiological childbirth. The lack of calendaring demonstrates the substantial disinterest of our politics in this important issue.

23. Cfr. *Ley 17/2020, de 22 de diciembre, de modificación de la Ley 5/2008, del derecho de las mujeres a erradicar la violencia machista* (*https://www.boe.es/boe/dias/2021/01/13/pdfs/BOE-A-2021-464.pdf*) which with respect to obstetric violence states, "*Violencia obstétrica y vulneración de derechos sexuales y reproductivos: consiste en impedir o dificultar el acceso a una información veraz, necesaria para la toma de decisiones autónomas e informadas. Puede afectar a los diferentes* ámbitos *de la salud física y mental, incluyendo la salud sexual y reproductiva, y puede impedir o dificultar a las mujeres tomar decisiones sobre sus prácticas y preferencias sexuales, y sobre su reproducción y las condiciones en que se lleva a cabo, de acuerdo con los supuestos incluidos en la legislación sectorial aplicable. Incluye la esterilización forzada, el embarazo forzado, el impedimento de aborto en los supuestos legalmente establecidos y la dificultad para acceder a los métodos anticonceptivos, a los métodos de prevención de infecciones de transmisión sexual y del VIH, y a los métodos de reproducción asistida, así como las prácticas ginecológicas y obstétricas que no respeten las decisiones, el cuerpo, la salud y los procesos emocionales de la mujer*".

Valencia places it within the scope of "asistencia sanitaria en el ámbito de la salud sexual y reproductiva de la mujer"[24].

Obstetric (as well as gynecological) violence is thus a misrecognized (or deliberately ignored) phenomenon although it is of large proportions[25]; in the absence of common definitions and standardized data collection processes, thus relying almost exclusively on quantitative and qualitative evidence from studies and analyses of various kinds (policy reports, academic articles, documents from civil society organizations, professional organizations) alarming figures nevertheless emerge: in the countries of the European Union they range from 21% in Italy, to 81% in Poland, and note that all women, regardless of their economic status, level of education or sociocultural background, are found to be at risk of obstetric violence[26]. Outside the Union, we note the recent

24. See Ley 1/2022 de segunda modificacion de la *Ley para la Igualdad de Mujeres y Hombres* (*https://www.boe.es/boe/dias/2022/03/28/pdfs/BOE-A-2022-4849.pdf*); and Ley 10/2014 *de Salud de la Comunitat Valenciana* (*https://www.boe.es/buscar/pdf/2015/BOE-A-2015-1239-consolidado.pdf*).

25. Recent studies on obstetric violence reveal a prevalence of 33% in Mexico, 44% in Argentina, 76% in Turkey, 15% in India, and 17% in the United States. High rates of obstetric violence have also been reported in Africa: 20% in Kenya, 20-28% in Tanzania, 65.3% in Ghana, 78% in Ethiopia, and 98% in Nigeria. A recent multinational study conducted in four sub-Saharan African countries found that 40% of women experienced obstetric violence during facility-based delivery and that abusive treatment is associated with an increased risk of maternal problems, such as obstructed labor and postpartum hemorrhage, and even death. On these data see A.A. Yalley, G. Jarašiūnaitė-Fedosejeva, B. Kömürcü-Akik, L. de Abreu, *Addressing obstetric violence: a scoping review of interventions in healthcare and their impact on maternal care quality*, *Frontiers in Public Health*, Vol. 12, 2024.

26. With respect to the data of the phenomenon, recent publications of the European Commission are worth mentioning: P. Quattrocchi, *Obstetric violence in the European Union: Situational analysis and policy recommendation*, European Union 2024 (*https://data.europa.eu/doi/10.2838/440301*); V. Rozée, C. Schantz, R. van der Waal *et al., Case studies on obstetric violence - Experience, analysis, and responses*, European Union, 2024 (*https://data.europa.eu/doi/10.2838/712175*). These are two Reports, the first under the leadership of Professor Patrizia Quattrocchi, a medical anthropologist at the University of Udine, who coordinated a working group of 27 experts from the *Scientific analysis and advice on gender equality in the EU* (SAAGE) network. The group collected and analyzed data on obstetric violence available in the member states, highlighting its scarcity

presentation to the British Parliament of a survey emblematically titled 'Birth Trauma', which collects and documents the traumatic experience of 1,311 women subjected to medieval levels of hygiene, denial of pain-relieving therapies, staff shortages, and permanent injury to them and their babies. The paper estimates that one in 20 women emerge from childbirth suffering from post-traumatic stress disorder[27]. Also deserving special attention is the recent innovative Project "*Respectful care. An innovative tool for a respectful maternity and childbirth care*" updated in real time by the *International platform on obstetric violence* (Ipov), thanks to which it will be possible to have more accurate data on the national and international incidence of this insidious form of violence[28].

both quantitatively and qualitatively; in fact, there are no studies carried out by Ministries of Health or other public bodies in Europe, so the available information comes from private research groups and is promoted by civil associations, as in the Italian case where the main research is still the one carried out in 2017 by Doxa on behalf of the Italian Observatory on Obstetrical Violence (OVOItalia) Survey that identified a 21% of Italian mothers with children in the 0-14 age group who experienced physical or verbal mistreatment during the first birth. See *https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/*.

The second paper, however, covers the specific analysis conducted in four countries-France, the Netherlands, Slovakia and Spain.

27. See *https://www.theo-clarke.org.uk/sites/www.theo-clarke.org.uk/files/2024-05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf*. In the survey The word 'terrified' appears in 266 statements, but 'shame', 'humiliation' and 'embarrassment' also appear, while the word 'broken' emerges in 328 submissions. The dominant narrative was one of discomfort at being overlooked, ignored or belittled at a time when one feels most vulnerable. Again, the poor quality of postnatal care is evident, women left to fend for themselves, sheets stained with blood, urine and feces, no intervention after numerous requests for assistance: "*About 6 hours after [my son] was born, I experienced a heavy bleed. I could see my white hospital bedsheets going red and I thought I was haemorrhaging again. I pressed my bell, nobody came. I pressed it again harder and nobody came. Another mum opposite me saw the sheets going red and my distress and went to get somebody. In that moment, I believed I was dying and my baby was going to be there in the hospital alone, with his mother dying next to him and nobody there who loved him or even knew his name. I was terrified*". These are not exceptions but the rule.

28. See *https://respectfulcare.eu/about-us/*.

Obstetric violence, as previously shown, appears to be strongly connected to the issue of women's self-determination over their own bodies and psycho-physical health, aspects, even today, sadly mortified by a medical, as well as socio-cultural, essentially patriarchal vision. The very naming of these behaviors has been stigmatized by medical associations, since the use of the term 'violence' could give rise to ambiguity, suggesting that such behaviors might be the result of the health care workers' intention to harm, when in fact they would be mostly attributable to systemic problems, lack of training or misunderstandings and not to intentional violence, and for this reason it would seem more appropriate to speak of 'health care mistreatment'[29]. But, again, words matter and these abusive behaviors constitute real forms of violence, even though they are often considered 'normal' or 'unavoidable' by the health workers themselves, behaviors that are completely unimaginable in any other health circumstance, but instead become inexplicably lawful at the time of childbirth[30]. For this reason, those who have long dealt with this case have sharply opposed to derubricating 'obstetric violence' to 'health care malpractice'. Indeed, substandard care is itself a violation of the human right (of women and men) to the enjoyment of the highest possible health, and the attempt to obstruct the recognition of this form of violence is itself a form of institutional and epistemic violence. The term 'obsteric violence' has been codified in national and international laws and conventions and has become a well-recognized legal term. This is why it is worrying that important scientific societies continue to disavow the validity of this

29. See A.F. Chervenak, R. McLeod-Sordjan, S.L. Pollet, M. De Four Jones *et al.*, *Obstetric violence is a misnomer*, in *American Journal of Obstetrics and Gynecology*, 2024, Vol. 230, Issue 3, Supplement, 1138. The Italian Association of Hospital Obstetricians Gynecologists is also along these lines, *https://www.aogoi.it/notiziario/violenza-ostetrica-termine/*.

30. One is reminded of Italian Law No. 219 of Dec. 22, 2017, containing "*Rules on informed consent and advance treatment provisions*", legislation that "*protects the right to life, health, dignity and self-determination of the person and establishes that no health treatment may be initiated or continued if lacking the free and informed consent of the person concerned, except in cases expressly provided for by law*". Thus, the importance of information and consent with respect to any medical act is well understood.

approach, disregarding international recommendations as well as the substantial scientific literature that already exists on the subject[31].

In conclusion, obstetric violence is a form of violence perpetrated against women and as such must be investigated, and fought, as it represents an act of oppression aimed at dispossessing women from the management and decisions inherent in their bodies at a time of extreme delicacy and vulnerability, reducing them to little more than a vessel for new life. In obstetric violence, religious anathema is wedded to the patriarchal view of society that mortifies women's decision-making capacity. Reasoning about obstetric violence thus means highlighting the 'schizoid' attitude of such a legal-social approach that, on the one hand, encourages women to become mothers, stigmatizes the termination of pregnancy by hindering it with only seemingly neutral interventions, only to abandon the woman to herself in the delicate moment of gestation and childbirth, dispossessing her from the management of an event that takes place in her body, because ultimately what matters is solely the continuation of the species, with respect to which the woman represents a mere 'accident' to which has incredibly been attributed

31. In this sense see S. Brigidi, A. Battisti, E. Skoko, C. Santos, L. Morais, M. Sadler, M. Candia, Á. Brocker, L. Contreras, A. Trouvé, S. Bish, C. Gonzaléz, J. Rossel, F. Yáñez, L. Werner, D. Mena-Tudela, A. Villegas, R. Galliardo, S. Fernandez, *Joint response from Latin American, European Obstetric Violence Observatories and others organizations all over Europe to the Joint Position Statement on Substandard and Disrespectful Care in Labor - Because Words Matter*, in *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 2024, and also T.H. Leite, M.A. Mesenburg, E.S. Marques*, Letter to the Editors. Terminology: obstetric violence,* in *American Journal of OBstetrics & Gynecology*, 2024. Also on the terminology aspect, see C. Pickles, '*Everything is Obstetric Violence Now': Identifying the Violence in 'Obstetric Violence' to Strengthen Socio-legal Reform Efforts*, in *Oxford Journal of Legal Studies*, 2024, in which the author points out that since the term 'obstetric violence' has become globally popular, it has had enormous application indicating any violation that occurs during reproductive health care. Doing so could run the risk of trivializing the concept by making it overly generalized and therefore difficult to apply in the legislative arena. The essay therefore proposes that violence qualifies as 'obstetrical' only if the violation of integrity occurs in the context of prenatal, *intrapartum* and postnatal care.

such an important task that, however, in her 'intrinsic deficiency', she cannot be independently capable of managing[32] .

Knowing and stigmatizing obstetric violence means dealing with human rights, women's dignity and, above all, working to build another fundamental block in the realization of the principle of equality, which must necessarily be declined also in the context of psycho-physical health.

Obstetric violence is one of the many forms of violence that affect women in an attempt to alienate them from the management of their own bodies; it is important to know it by the right name, which is that of 'obstetric violence', and it is important that States and the international community move to regulate this insidious form of overpowering legacy of an increasingly intolerable patriarchy.

32. He refers to the 'deficient woman' the German psychiatrist Moebius in a paper he wrote in 1900 (P.J. Moebius, *The Mental Inferiority of Woman*, Einaudi, 1978) in which the author, without any shame or ambiguity states that: "*the female, in the human species, must bear children, but in addition to that, she must take care of them, ...the mental deficiency of woman not only exists, but moreover is necessary; it is not only a physiological fact, but it is also a physiological postulate. If we want a woman, who can fulfill her maternal task well, it is necessary that she should not have a masculine brain...Exalted modern-style women give birth badly and are bad mothers...The law should also take into account the mental deficiency of the woman...If we deem it necessary to point out how the woman is mentally deficient compared to the man, we do not for that reason believe that we have said something prejudicial to the woman. Her prerogatives are extruded in quite a different direction from that by which masculine prerogatives are extruded, and the differentiation of the sexes seems to us to be a double path appropriately marked out by nature, walking by which men and women should not find themselves too badly off. However, when one considers more closely the life of woman, one must agree that Nature has been really hard on her*". In short, woman is considered physiologically deficient, and this is not a value judgment but a simple scientific finding, the result of rigorous analysis and research that the author defended in all subsequent editions. Today, *politically correct* language would prevent the publication of such reasoning, but can we really say that such prejudices have been completely overcome?

Ob-Gyn Violence at the Crossroads among the Council of Europe, the European Union, and Comparative Responses

Costanza Nardocci

1. A Neglected Phenomenon? From Europe to the United Nations, someone calls it Ob-Gyn violence

"According to the mother's account, the death of the infant Elena was the tragic and traumatic outcome of willful medical neglect violent intimidation, and anti-Roma abuse. A maternity ward should be a place where expectant mothers feel safe, protected, and respected. Instead, Marica Mihajlović found herself at the cruel intersection of racism, gender-based and institutional violence. This must end, and perpetrators must be held accountable for obstetric violence".

These were the words of the President of the European Roma Rights Centre (ERRC) about a case of ob-gyn violence that happened in Serbia in 2024. The importance of the statement should be framed

in a broader context where, unfortunately, obstetric and gynecological violence has not yet been fully addressed, nor tackled as it should.

The same should be said for a peculiar form of ob-gyn violence, that is forced sterilization just recently, and for the very first time in history, declared not in compliance with a national Constitution. In July 2024, the Supreme Court of Japan has, thus, held that forced sterilization, performed for eugenic purposes, to the detriment of disabled people should be considered in violation of the Constitution of Japan.

These two episodes are emblematic of a new history of violence against women that must be taken seriously from now on.

Undoubtedly, until now, the attention paid by domestic laws and international human rights laws to violence against women and domestic violence represents a core trait of the current debate on women and their rights. Likewise, needless to say, recent years have witnessed a rapid development of supranational and domestic regulation on violence against women.

Although this increasing growth in the number of domestic laws and supranational initiatives aimed at strengthening women's protection against acts of violence, ambiguities persist when it comes, among others, to obstetrical and gynecological activities.

The controversy revolves, in fact, around the boundaries of what constitutes violence and what, therefore, should be – even criminally – sanctioned by the law and what, instead, should fall out of this categorization.

Not surprisingly, therefore, obstetric and gynecological violence constitutes a crucial example of the challenges faced by the definition of violence against women[1]. For some, not considered violence per se, but, instead, medical negligence or purely malpractice without any gendered contours; for others emblematic of a new frontier of violence against women covering all cases where women are exposed to treatments resulting in a violation of their fundamental rights as women

1. Although the academic literature in the legal scenario is just now approaching the issue on a more structural basis, worth mentioning are the reflections of C. Barata, V. Simoes, F. Soromenho, *Obstetric violence: a form of gender-based violence*, in S. Banwell *et al.* (eds.), *The Emerald International Handook of Feminist Perspectives on Women's Acts of Violence*, Emerald Publishing, 2003.

in the context of reproduction or every medical procedure involving women's reproductive organs.

In such a dynamic scenario, the United Nations took a clear stand against ob-gyn violence in 2019. The UN Special Rapporteur on violence against women called for called for "[a] human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence» and, also, emphasized the need to strengthen this same approach at the domestic level.

The Article will explore the European approach to ob-gyn violence without overlooking the domestic comparative analysis. Eventually, the Article aims to disclose the challenges and the criticisms of the current responses but, mostly, of their absence and to suggest some preliminary guidelines to orient a hopefully timely European legislative intervention.

2. A Hidden Phenomenon? The Reality Behind Data and Grassroots Initiatives

Although ob-gyn violence is scarcely addressed in the legal context, empirical data portray a different reality. A country-specific investigation shows the weight of the phenomenon, which unfortunately continues to be largely underreported in the European continent.

According to the report issued by the Care Quality Commission, *State of Care*[2], in the United Kingdom, in 2022, 34% of births have been considered traumatic with features overlapping the concept of ob-gyn violence and in 39% of cases maternity wards were described as in need of improvement or "inadequate". In France, a study[3] conducted in 2023 on 123 women found that 8,13% reported suffering disrespectful attitudes during childbirth and after and that *postpartum* depression

2. See the Report available is available at the following link: *https://www.cqc.org.uk/publications/major-report/state-care/2022-2023*.

3. See Leavy, E., Cortet, M., Huissoud, C. *et al.*, *Disrespect during childbirth and postpartum mental health: a French cohort study*, in *BMC Pregnancy Childbirth*, 2023, 241 ff.

2 months after childbirth was correlated with noted disrespect during pregnancy. In 2019, the Report *Mistreatment and Violence against Women During Reproductive Health Care and Childbirth in Finland A response to the call for submissions by the OHCHR-UN*[4] described the *status quo* of ob-gyn violence in the Finnish legal order.

In Switzerland, a national study recognizes that 26% of mothers have been informally coerced into medical procedures during childbirth[5]. In Belgium, according to the survey released in 2021 by the NGO *Plateforme citoyenne pour une naissance respectée*[6], 1 out of 5 women reported to have undergone unnecessary harmful interventions. Another study, this time about Germany and the Netherlands, revealed that approximately 76,3% of women experienced obstetric violence during childbirth[7].

Leaving aside the data concerning the Italian legal order, that have been already discussed, other data can be found, even though reference continues to be made to disaggregated data resulting from isolated studies, while no official data is traceable about the incidence of ob-gyn violence in the European continent, at least.

Among these, one research released in Spain speaks of 67% of reported cases of gynecological and obstetric violence. The Spanish case is of paramount importance as it is one of the rare cases in which

4. The report was compiled by the Minä Myös Synnyttäjänä campaign in collaboration with the NGO Aktiivinen Synnytys Ry and can be read in full here: *https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Aktiivinen_Synnytys_Ry_Finland.pdf*.

5. The study was conducted by S. Oelhafen, M. Trachsel, S. Monteverde, L. Raio, E.C. Müller, *Informal coercion during childbirth: risk factors and prevalence estimates from a nationwide survey among women in Switzerland*, 2020 referred to in S. Rauch, L. Arnold, Z. Stuerner, J. Rauh, M. Rost, *A true choice of place of birth? Swiss women's access to birth hospitals and birth centers*, in *PLoS One*, 2022. The fulltext can be read at the following link: *https://www.ncbi.nlm.nih.gov/pmc/Articles/PMC9258807/*.

6. Data can be found on the NGO's webpage: *https://www.naissancerespectee.be/la-plateforme/*.

7. Reference is made to the study published by M.L. Reuther, Prevalence of Obstetric Violence in Europe: Exploring Associations with Trust, and Care-Seeking Intention, University of Twente, 2021.

it has been established as an ad hoc remedy to bring claims of ob-gyn violence before Courts, although only in Catalunya.

More recently, as a response to the lack of investigation into this peculiar type of violence against women, the European Parliament published a report, collecting data, legislative regulations, and best practices enacted within the 27 Member States about ob-gyn violence. The report is the most timely and official document entirely dedicated to ob-gyn violence, whose most notable aim is to describe and examine the state of the art of policies to contrast obstetric and gynecological violence adopted at the European Union and state levels. The Report includes statistical data[8], depending on the forms of ob-gyn violence taken into consideration, highlighting the vast heterogeneity of manifestations ob-gyn violence might take.

Before the conclusions and the recommendations, it is particularly interesting the point of departure of the study. Reflecting the main challenge featuring any investigation about ob-gyn violence even beyond the European scenario, the Report insists on the criticisms deriving from the heterogenous approaches to ob-gyn violence across the Member States. The absence of a commonly accepted definition of gynecological and obstetric violence among the 27 EU Member States, which mirrors the absence of legislative regulation on this form of violence, is depicted as the major barrier in comparing legislative initiatives and policies adopted at the state level[9]. In short, the Report highlights that "the lack of a commonly agreed definition has severe consequences, including making the concept difficult to operationalize

8. The Report is very detailed in describing its methodological approach. As stated in the Report, "[t]he research team first carried out a number of interviews with EU and international stakeholders to collect information on the broad political context and issues at stake in relation to obstetric and gynecological violence. Further on, EU and international data and information were collected and reviewed, including legal and policy documents, academic publications as well as publications issued by non-institutional actors, such as CSOs and pan-European associations and federations. The data collection exercise was carried out at the MS level to obtain some information on the prevalence and awareness of the issue and potential policy/sector initiatives implemented to address it". For a list of the stakeholders, see Annex 3 of the Report.

9. On this, see, the Report at 12.

in policies and programs aiming at preventing the issue and enabling women access to redress mechanisms. In addition to issues with terminology, the lack of harmonized data at the EU level but also within MSs themselves means that it is difficult to assess the prevalence of the problem and its manifestations"[10].

To respond to the above-mentioned issues, the Report recommends, first, that European institutions and bodies should make efforts to "promote a reflection at EU level on the definition of obstetric and gynecological violence"[11] through the establishment of working groups to come up with a definition of the phenomenon at stake. In the same direction, goes the suggestion to the EU Commission to bring ob-gyn violence on the agenda of the recently established *EU network on the prevention of gender-based violence and domestic violence*. Besides the recommendations for EU institutions, the Report then calls on the Member States to: support studies on ob-gyn violence, including funding qualitative research and collecting women's testimonies. Equally important are the recommendations the Report reserves to healthcare professionals[12] and women's rights, required to deepen the reflection on ob-gyn violence to support legislative initiatives.

Lastly, and before examining the challenges of the definition of obstetric and gynecological violence, it is worth recalling which forms were considered as such and covered by the Report[13]. These include psychological, physical, and sexual abuse during obstetric and gynecological consultations; forced medical acts or medical acts performed without consent; non-medically necessary (harmful) procedures; and refusal or delay of care.

10. See, the Report at 101.

11. See, the Report at 103.

12. The direct involvement of healthcare professionals is a peculiar trait of the Report. More specifically, the Report clarifies that healthcare professionals should be required to: "[c]ontribute to the work undertaken to provide a practical definition of the phenomenon and to measure violence by reflecting upon available proxies at national/practice level. Collaborate with researchers, support access and assess existing data. Encourage practitioners to participate in European reports on perinatal health", see the Report at 105.

13. See, the Report at 15 – 16.

Eventually, the lack of laws and policies concerning ob-gyn violence at the supranational and state levels favored the activists of the NGOs aimed at pushing legislative regulations. Examples, among others, come from France with the campaign *#PayeTonUtérus*[14] and *#balancetongyneco*[15], which lead to the publication in 2018 of the study *Actes sexistes durant le suivi gyneécologique et obstétrical: reconnaître et mettre fin à des violences longtemps ignores*[16], and Croatia with the campaign #prekinimošutnju *(#BreakTheSilence)*[17].

3. Defining Ob-Gyn Violence

There is currently no global consensus on what constitutes ob-gyn violence, what forms it may take, or where the line should be drawn between gender-based violence and medical malpractice.

The term obstetric and gynecological was first introduced by Blundell in an Article published by the Lancet in 1987[18], without nevertheless being later fully endorsed by the international community and national jurisdictions.

Not explicitly defined as ob-gyn violence, the World Health Organization defines such acts as obstetric and gynecological violence "as any abuse, disrespect, and mistreatment in childbirth caused by healthcare professionals that result in violations of women's dignity"[19].

14. See the news published by *LeMonde* on 25 November 2025 at the following link: *https://www.lemonde.fr/societe/Article/2014/11/26/payetonuterus-contre-les-gynecologues-irrespectueux_4529587_3224.html*.

15. This is instead a documentary released in 2022, that can be watched on Prime Video.

16. The full text of the study can be read at the following link: *https://www.haut-conseil-egalite.gouv.fr/IMG/pdf/hce_les_actes_sexistes_durant_le_suivi_gynecologique_et_obstetrical_20180629.pdf*.

17. See the website here: *https://www.prekinimosutnju.hr*.

18. J. Blundell, *Lectures on the theory and practice of midwifery. Delivered at Guy's hospital by Dr James Blundell. Lecture 28: After-management of floodings, and on transfusion*, in Lancet, 1987.

19. World Health Organization, *Statement on the Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth*, World Health Organization, Geneva, Switzerland, 2015.

Additionally, again, the WHO clarifies the manifestations this peculiar type of violence may take, including "outright physical abuse, humiliation caused by verbal abuse, lack of confidentiality, and neglect that results in unnecessary pain and avoidable complication"[20].

In the following years, another international organization offered its definition of ob-gyn violence.

In 2019, the Council of Europe's Committee on Equality and Non-Discrimination described obstetric and gynecological violence as "a form of violence against women and girls"[21], covering the following conducts: "violent practices perpetrated towards women during medical procedures and gynecological consultations, inappropriate or non-consensual acts, sexist behaviors during medical consultations"[22].

Despite avoiding suggesting a definition, the above-mentioned 2024 European Union Report on obstetric and gynecological violence, nevertheless, identifies two elements that are usually recurrent in this form of violence. The EU Report speaks of violence that should be situated "at the convergence of two structural crises: discrimination based on gender and the under-resourcing of healthcare systems and institutions"[23], shedding light on two if not elements, at least causes that are likely behind ob-gyn violence. The first one – discrimination based on gender – should be reflected in the subordinated position of the woman, as patient, with a resemblance with all other types of power relationships among individuals and social groups often leading to discriminatory and violent consequences.

20. *Ibidem*. More specifically, the WHO identifies seven typologies of verbal abuse, physical abuse, sexual abuse, social discrimination, neglect of care, and inappropriate use of tools and devices or actions performed without the person's consent

21. Reference is made to the CoE's *Parliamentary Assembly debate* on 3 October 2019 (34th Sitting) (see Doc. 14965, report of the Committee on Equality and Non-Discrimination, rapporteur: Ms Maryvonne Blondin). *Text adopted by the Assembly* on 3 October 2019 (34th Sitting), link: *https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28236*.

22. *Ibidem*.

23. See, above, the EU Report.

Though the European continent as a whole continues to be silent, avoiding any attempts to officially define ob-gyn violence at the supranational and domestic level, the Latin and South American[24] experiences lead to highly different outcomes.

Venezuela[25] (2007) and Argentina[26] (2009) have both enacted legislation defining ob-gyn violence[27]. Under Venezuela's law, ob-gyn violence consists of the "'appropriation of women's bodies and reproductive processes by health professionals through dehumanizing treatments, abuses in medicalization, or the pathologizing of natural processes, lead[s] to loss of autonomy and decision-making capacity over their bodies and sexuality, [and] negatively affects women's quality of life"[28]. Argentina's law, similarly, qualifies ob-gyn violence as "violence perpetrated on women's bodies and reproductive processes by health professionals. This is reflected through dehumanizing treatments, abuses in medicalization, and pathologizing of natural processes"[29]. The trend towards the recognition of obstetric and gynecological violence as a form of gender-based violence is not limited to Venezuela and Argentina. In the following years testified recognized, the same approach spread all over the continent with further notable cases of States acknowledging ob-gyn violence under domestic laws. Beyond Latin and South America, in Europe, the only notable example is Catalunya, Spain, which through its Ministries of Health and Equality and Feminisms, in 2020 launched the Plan to address obstetric violence and the violation of sexual and reproductive rights[30].

24. The leading example of Venezuela and Argentina was similarly followed by Bolivia in 2013, Panama in 2013, and Mexico in 2014.

25. See Law No. 38 of 2007.

26. See Law No 26 of 2009.

27. For a comment on the legislative novelties brought up by Venezuela's and Argentina's laws, see, among others, C.R. Williams *et al.*, *Obstetric Violence: A Latin American Legal Response to Mistreatment During Childbirth*, in *BJOG*, 2018, 201 ff.; C. Herrera Vacaflor, *Obstetric Violence: A New Framework for Identifying Challenges to Maternal Healthcare in Argentina*, Reproductive Health Matters, 2016, 65 ff.

28. See Article 15.

29. See Article 15.

30. Reference is to Law No. 17 of 2020, 22 December 2020, which amended Law No. 5 of 2008.

Definitions as such endorsed under Venezuela's and Argentina's laws were later suggested in the academic debate around ob-gyn violence[31].

Instead of focusing on the violent facets of the practice, one, in particular, hinges on the structural disadvantage and vulnerabilities suffered by the victims. This framework links obstetric violence to systemic racial subordination, that links it to racism. In line with this definition, ob-gyn violence should be framed in the broader context of what has been called "obstetric racism". The term "obstetric racism" should cover "the mechanisms and practices of subordination to which Black women and people's reproduction are subjected that track along histories of anti-Black racism during preconception, pregnancy, prenatal care, labor, birth, and postpartum care. It characterizes situations when obstetric patients experience reproductive dominance by medical professionals and staff compounded by a patient's race or the history of racial beliefs that influences the treatment or diagnostic decisions"[32].

Although it cannot be depicted in any case as a form of violence linked to racism, meaning "obstetric violence", ob-gyn violence, nevertheless, reproduces a very similar construction of relationships based on domination and subordination, featuring phenomena such as racism and discrimination.

The terms obstetric and gynecological violence also appeared before Courts. In *Rinat Dray v. Staten Island University Hospital and Others*, the New York Supreme Court Appellate Division was asked to decide a case about a pregnant woman who was forced to have a cesarean

31. See, among others, V. Savage, A. Castro, *Measuring Mistreatment of Women During Childbirth: A Review of Terminology and Methodological Approaches*, in *Reproductive Health*, 2017, link: *https://link.springer.com/Article/10.1186/s12978-017-0403-5#citeas*; R. van der Waal, K. Mayra, A. Horn, R. Chadwick, *Obstetric Violence: An Intersectional Refraction through Abolition Feminism*, in *Feminist Anthropology*, 2023, 91 ff.

32. The term "obstetric racism" started to be used in the United States. On this, among others, see D.A. Davis, *Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing*, in *Medical Anthropology*, 2019, 560 ff.; R. Maurice, We bawl so we are heard: the stories we must tell about obstetric racism. *Sexual and Reproductive Health Matters*, 2023; J.K. Taylor, *Structural racism and maternal health among black women*, in *J. Law Med Ethics*, 2020, 506 ff.

surgery over her repeated and competent objection. Interestingly, it was the *amicus curiae* of the NGO Lawyering for Reproductive Justice to emphasize the urge to use the term obstetric violence to describe the conduct the victim was exposed, defining the former as the "eradication and remedy of coercion and mistreatment during childbirth"[33].

To conclude on this point, which is preliminary to the following investigation, if there is no unanimous definition of ob-gyn violence, there is perhaps more consensus regarding its manifestations.

These include nowadays generally considered forms of obstetric or gynecological violence: procedures performed without the woman's informed consent; "episiotomies or performing episiotomies after delivery for training; manual revision of women's uterine cavities without pain relief; inserting long-term birth control mechanisms directly after birth; collective vaginal examinations for training purposes; tying women's legs to the delivery table; health-care providers' failing to introduce themselves before treating women; and forced sterilizations"[34].

In such a dynamic scenario, Europe has a long way to go.

But, first, let's turn an eye to the European approach to ob-gyn violence, which shows a clear preference for soft law mechanisms instead of resorting, until now at least, to hard law.

4. Hard Law? No, Soft Law

As previously noted, Europe has yet to adopt a binding legal definition of this form of violence either at the supranational level or at the state level.

33. The full text of the judgment and of the Amicus Curiae can be read at the following link: *https://reproductiverights.org/wp-content/uploads/2021/02/Rinat-Dray-v.-Staten-Island-University-Hospital.pdf*.

34. The list of practices is offered by C. Pickles, *Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa*, in *South African Crime Quarterly*, 2015, 5 ff. The A. also includes other conducts under the concept of ob-gyn violence. These are: "[o]ther forms of physical violence that have been labelled as obstetric violence include slapping; humiliating pregnant women by forcing them to clean the delivery room after birth; performing clitoridectomies and virginity inspections where consent is socially coerced; and deliberate refusal of pain relief", 3.

Despite the increasing efforts in tackling violence against women that have been put in place and even grown in numbers in recent years, both the Council of Europe and the European Union have approached the matter with caution.

Neither of the two international organizations has chosen to include obstetric and gynecological violence among the variety of gender-based violence instruments adopted in the past few years.

The avoidance of hard law mechanisms does not mean that obstetric and gynecology violence has been entirely neglected in Europe. Conversely, as it will be later examined, the Council of Europe and the European Union preferred to approach obstetrics and gynecology by distance. Put differently, the Council of Europe, especially, has repeatedly opted for soft law documents containing references to ob-gyn violence without endorsing the view that this type of violence should be formally protected under the CoE's Convention on Violence against Women.

Not differently, the European Union excluded ob-gyn violence from the ambit of application of its Directive on gender-based violence.

Thus, soft law currently constitutes the primary and most significant approach of the status of ob-gyn violence in Europe.

The same has to be said about the member States of the Council of Europe and the European Union, with the sole exception of Catalonia (Spain) and Portugal, no EU or Council of Europe member state has enacted specific legislation.

In the following paragraphs, the following sections will examine in more detail before turning to non-European developments.

5. The Council of Europe

The Council of Europe does not formally recognize obstetric and gynecological violence as a distinct form of violence to be isolated and separately handled.

The Council of Europe's Convention on the Prevention and Repression of Violence against Women (the so-called Istanbul

Convention)[35] does not include any explicit reference to obstetric and gynecological violence. Moreover, any mention of violent practices suffered by women and girls in connection with reproduction or reproductive rights is notably absent from the text.

While it does not specifically consider obstetric and ob-gyn violence, the Istanbul Convention lists at least three conducts, that clearly fall within its conceptual scope.

The first two are forced sterilization and forced abortion, both addressed under Article 39, which emphasizes the lack of prior and informed consent as the defining element. The Convention defines *forced abortion* as "performing an abortion on a woman without her prior and informed consent". The Explanatory Report[36] reinforces this interpretation, stating that what qualifies the procedure as forced abortion is precisely the absence of informed consent. Forced sterilization, instead, is defined as an act of "surgery which has the purpose or effect of terminating a woman's capacity to naturally reproduce without her prior and informed consent or understanding of the procedure"[37]. The Explanatory Report further elaborates on on this point. Reiterating that the lack of consent remains the decisive element. It also clarifies the definition of sterilization, specifying that "the offense is committed if surgery is performed which has the purpose or effect of terminating a woman's or girl's capacity to naturally reproduce if this is done without her prior and informed consent"[38], and that "[t]he term sterilization refers to any procedure which results in the loss of the ability to naturally reproduce"[39].

Alongside forced abortion and forced sterilization, the other conduct that the Istanbul Convention includes among the forms of

35. The Council of Europe Convention on preventing and combating violence against women and domestic violence can be read at the following link: *https://www.coe.int/en/web/conventions/full-list?module=treaty-detail&treatynum=210*.

36. The full text of the Explanatory Report is available here: *https://rm.coe.int/1680a48903*.

37. See Article 39 of the CoE's Istanbul Convention.

38. See § 250.

39. *Ibidem*.

violence against women, refraining from qualifying it as ob-gyn violence is female genital mutilation. In this last case, it is interesting to note that the Istanbul Convention seems much more concerned in describing the conduct as a manifestation of a "traditional practice"[40] rooted in cultural or customary practices rather than as a form of gynecological violence.

Also, and this applies to all the three practices sanctioned under the Istanbul Convention, there is an unfortunate lack of acknowledgment of the intersection among reproduction, women's bodies, and their rights that, instead, play a central role in the definition of ob-gyn violence.

Besides the CoE's Istanbul Convention and some judgments issued by the European Court of Human Rights, the Council of Europe's approach is featured by the predominance of soft law responses that have paved the way in the last years through resolutions and recommendations issued by the Parliamentary Assembly of the Council of Europe.

The first document, although motion No. 14495 has not been discussed in the Parliamentary Assembly, was published on January 26th, 2018[41].

The motion does not suggest a definition of obstetrical and ob-gyn violence violence, but it connects it with cases of violence "experienced while giving birth or during gynecological consultations"[42], listing forms such as "sexism, rough treatment, humiliation, episiotomies, and cesarean sections to which the women concerned did not give their consent, or even segregation in some maternity hospitals"[43]. Beyond the urge to take the phenomenon "seriously", it is worth mentioning the choice of the Council of Europe to explicitly specify that the discussion about ob-gyn violence does not imply to "point

40. See § 198 of the Explanatory Report about Article 38 of the CoE's Istanbul Convention.

41. The motion is titled Obstetric and Gynecological violence and the full text can be read here: *https://pace.coe.int/pdf/7d2ebbe69464202d1615641c22d224544591368751c60787ad730e204bd4756a?title=Doc.%2014495.pdf*.

42. *Ibidem.*

43. *Ibidem.*

the finger at a specific profession"[44], but, rather, to "take stock of the situation to recommend to Council of Europe member States the necessary measures to change practices and ensure medical care for women, while respecting their rights, their bodies and their health"[45].

A second and more significant step came with Resolution No. 2306 of 2019 fully dedicated to obstetrical and gynecological violence[46], published five years after the coming into force of the Istanbul Convention.

While acknowledging that the Istanbul Convention falls short in explicitly addressing forms of obstetric and gynecological violence, and emphasizing the critical importance of awareness-raising efforts undertaken by non-governmental organizations – as well as the authoritative intervention of the United Nations Special Rapporteur on violence against women – the Resolution calls upon the Member States of the Council of Europe to adopt and implement a comprehensive range of legal and policy measures. Among these, "conduct information and awareness-raising campaigns on patients' rights and on preventing and combating sexism and violence against women, including gynecological and obstetrical violence"[47]; "provide specific training for obstetricians and gynecologists and raise awareness of gynecological and obstetrical violence as part of this training"[48]; "propose specific and accessible reporting and complaint mechanisms for victims of gynecological and obstetrical violence, within and outside hospitals, including with ombudspersons"[49].

Lastly, the Resolution paid significant care to the duty to inform women and girls and to acquire their consent before any procedures, as well as the need to provide special support and assistance to women and girls belonging to vulnerable groups.

Beyond the Conventional system of human rights, it is worth recalling that the right to health is formally recognized under the Council of Europe's European Social Charter under Article 11, § 2. The provision

44. *Ibidem.*

45. *Ibidem.*

46. The full text of the Resolution can be read at the following link: *https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28236*.

47. See § 8.5.

48. See § 8. 8.

49. See § 8.10.

invites the Contracting States to "provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibilities in matters of health"[50].

The provision makes it clear that, under the Council of Europe, there is at least one principle to anchor women's reproductive rights violations besides the examination of submissions under the standpoint of Articles 3 and 8 of the ECHR, which as known, do not explicitly safeguard nor social rights nor the right to health and, among these, no right to health.

However, as the analysis of the ECtHR's case law will show, there might still be room for tackling ob-gyn violence under the European Convention of Human Rights to the extent the ECtHR will be willing to widen the ambit of application of conventional rights and to favor their evolutive interpretation favoring their evolutive interpretation and girls' rights.

5.1. The Case Law of the European Court of Human Rights: Connecting VAW to Reproduction

Another way to look at whether obstetric and gynecological violence gained some in the Council of Europe stems from the analysis of the European Court of Human Rights case law on women's rights and reproductive rights.

A review of the relevant case law permits the classification of the ECtHR's judgments into five distinct categories, each of which may be interpreted as reflecting a specific form of obstetric and gynecological (ob-gyn) violence. These categories encompass: female genital mutilation; infringements on privacy during childbirth; violations of the patient's right to receive adequate information; instances of forced sterilization; and, finally, the mistreatment of individuals seeking abortion care.

Female genital mutilations represent, together with forced sterilizations, the only types of ob-gyn violence that benefit from a legal recognition as forms of violence against women and girls as established under the Council of Europe's Istanbul Convention.

Despite the universal condemnation of FGMs, which goes beyond the European context, the few cases issued by the ECtHR have until

50. The full text of the European Social Charter can be read at the following link: *https://www.coe.int/en/web/european-social-charter/charter-texts*.

now seldom adequately responded to the submissions of the applicants, by way of a questionable resort to the margin of appreciation doctrine. Other times, applications were declared inadmissible.

The ECtHR developed a case law affirming the noncompliance of the practice at stake with the ECHR, because considered in violation of Article 3 ECHR interpreted as a form of inhuman and degrading treatment.

Despite the uncontested qualification of female genital mutilations as ill-treatments, within the meaning of Article 3 ECHR, the ECtHR has not yet gone too far to sanction States' decisions to, for example, expel migrant women and young girls when there existed a risk of being subjected to female genital mutilations once returned to their country of origin.

In other words, when the ECtHR had to confront with States' policies on migration, recessive weight has always been attributed to women's rights and children's best interests. Since the ECtHR claims to have no competence to judge domestic regulations about forced expulsions, because States are better placed and afforded a wide margin of appreciation in these matters, cases involving female genital mutilation, therefore a form of ob-gyn violence, were not sanctioned under the European Convention of Human Rights.

In short, if the ECtHR's approach towards FGMs is broadly featured by self-restraint, he prevalence of decisions of inadmissibility and the frequent resort to States' margin of appreciation, there are judgments worth recalling.

The first is *Collins and Akaziebie v. Sweden*[51], about a Nigerian woman who sought asylum in Sweden. The case was 25 years old and pregnant to avoid being subjected to female genital mutilation in her country of origin. The applicant also claimed, that in Nigeria women had to undergo a serious type of FGM at childbirth and that she wished to protect her daughter from being forcibly subject to this practice. In the judgment, the ECtHR held, first, that "it is not in dispute that subjecting a woman to female genital mutilation amounts to ill-treatment contrary to Article 3 of the Convention.

51. ECtHR, *Collins and Akaziebie v. Sweden*, [Third Section], no. 23944/05, 8 March 2008.

Nor it is questionable that women in Nigeria have been traditionally subjected to FGMs"[52]. However, the ECtHR declared the application manifestly ill-founded, because the applicant failed to prove and substantiate that she and her daughter were exposed to a real and concrete danger.

Without relying on the obstacles caused by migration domestic policies and recalling the margin of appreciation doctrine, the line of reasoning that places on the applicant's side the burden of the proof of the recurrence of serious risk is highly controversial. It neglects, first, the condition of vulnerability of the applicant and, secondly, it does it especially by avoiding to apply the rule of the inversion of the burden of the proof, instead, plainly admitted in discrimination cases. The weaknesses of Article 14 ECHR were very clear. Parties did not invoke Article 14 ECHR in conjunction with Article 3 ECHR and, as a consequence, the ECtHR has an "easy job" in refusing to interpret the practice as a form of discrimination gender-based.

Such an approach has unfortunately so far never been abandoned. Yet, to date, no ECtHR judgments found violations of the European Convention in FGMs cases.

As a result, the following cases shared *Collins and Akaziebie v. Sweden*'s same fate. In R.*B.A.B. and Others v. The Netherlands*[53] and *Sow v. Belgium*[54], the ECtHR found no violation of Articles 3 and 13 ECHR.

A second angle of investigation involves cases of invoked neglected privacy during childbirth. These cases range from the admitted possibility[55] or, conversely, the denial[56] to decide the conditions of giving birth whether at home or forcibly at a healthcare facility. Other cases involved the damages caused to the woman and the baby due to

52. *Ibidem*.

53. ECtHR, *R.B.A.B. And Others v. The Netherlands*, [Third Section], no. 7211/06, 7 June 2016.

54. ECtHR, *Sow v. Belgium*, [Second Section], no. 27081/13, 19 January 2016.

55. ECtHR, *Ternovszky v. Hungary*, [Second Section], no. 67545/09, 14 December 2010.

56. ECtHR, *Dubská and Krejzová v. the Czech Republic*, [Grand Chamber], nos. 28859/11 and 28473/12, 15 November 2016.

the delay in birth procedures. Others feature the lack of consent of the woman to be exposed to the entire procedure of her pregnancy at the present of med school students.

The case law is quite ambivalent. While in *Ternovszky v. Hungary*, the ECtHR found a violation of Article 8 ECHR due to the prohibition, contrary to the European Convention, opposed to the applicant to give birth at home[57], the opposite conclusion was reached in *Dubská and Krejzová v. the Czech Republic*, despite the similarities between the circumstances of the cases. In the former, the ECtHR recognized the "right of choosing the circumstances of becoming a parent", in the latter it emphasized the risks associated with giving birth at home in the interest of the newborn[58].

A third circumstance, that could be considered as depicting a form of ob-gyn violence, concerns the patients' right to be duly informed.

The ECtHR had the chance to confront the issue in *Codarcea v. Romania*[59], where, very briefly, the Court of Strasburg disregarded the acquisition of the patient's consent before subjecting her to medical procedures impacting her future ability to reproduce.

57. The judgment reads as follows: "[t]he notion of personal autonomy is a fundamental principle underlying the interpretation of the guarantees of Article 8. Therefore, the right concerning the decision to become a parent includes the right of choosing the circumstances of becoming a parent. The Court is satisfied that the circumstances of giving birth incontestably form part of one's private life for the purposes of this provision".

58. More specifically, the ECtHR noted that: "the risk for newborns is higher in respect of home births than in respect of deliveries in fully staffed and equipped maternity hospitals, is aware that, even if a pregnancy seems to be without any particular complications, there can arise unexpected difficulties during the delivery, such as the acute lack of oxygen supply to the fetus or profuse bleedings, or events which require specialized medical intervention, such as a caesarean section or the need to put a newborn on neonatal assistance. Moreover, in the course of a hospital birth, the institution can immediately provide the necessary care or intervention, which is not true of a home birth, even one attended by a midwife. The time spent getting to a hospital should such complications occur could indeed give rise to increased risks to the life and health of the newborn or of that of the mother"

59. ECtHR, *Codarcea v. Romania*, [Third Section], no. 31675/04, 2 June 2009.

Easily connected to ob-gyn violence are, however, the judgments released by the ECtHR about mistreatments in abortion care.

The ECtHR delivered judgments, especially against Poland, where it found that the lack of care during abortion procedures amounted to a violation of Article 3 ECHR, safeguarding the right to not be subjected to inhuman and degrading treatments.

In *P. and S. v. Poland*[60], the ECtHR, for the first time, tackled the challenges faced by young girls seeking abortion procedures following rapes and sexual assaults. Regardless of the specifics of Polish law, which, nowadays represents one of the more restricted abortion laws in the European Union, the ECtHR recognized that the delay in allowing the young girl to abortion care could be considered in compliance with the European Convention.

Interestingly, the ECtHR recognized, first, that the humiliation suffered by the victims fell within the ambit of application of Article 3 ECHR, in that "it cannot be excluded that acts and omissions on the part of the authorities in the field of health-care policy may in certain circumstances engage their responsibility under Article 3"[61]. Moreover, it went on to state that the victim in the case, a 14 years old girl, was in a condition of particular vulnerability and that "[she] was treated by the authorities in a deplorable manner and that her suffering reached the minimum threshold of severity under Article 3 of the Convention"[62].

Going beyond Article 3 ECHR, the ECtHR held, in particular, that, first, "effective access to reliable information on the conditions for the availability of lawful abortion, and the relevant procedures to be followed, is directly relevant for the exercise of personal autonomy"[63] and, recalling *Evans v. The United Kingdom*[64], it reiterates "that the notion of private life within the meaning of Article 8 applies both to decisions to become and not to become a parent"[65]. More importantly,

60. ECtHR, *P. and S. v. Poland*, [Fourth Section], no. 57375/08, 30 October 2012.

61. *Ibidem*, § 160.

62. *Ibidem*, § 168.

63. *Ibidem*, § 111.

64. ECtHR, *Evans v. The United Kingdom*, [Grand Chamber], no. 6339/05, 10 April 2007.

65. ECtHR, *P. and S. v. Poland*, § 111.

the judgement heavily relied on the paramount importance that should be given to the so-called time factor. Yet, "the nature of the issues involved in a woman's decision to terminate a pregnancy or not is such that the time factor is of critical importance"[66], with the consequence that "the procedures in place should therefore ensure that such decisions are taken in good time"[67]. In the ECtHR's view, all this considered, there has also been a violation of Article 8 ECHR due to "the Court concludes that the authorities failed to comply with their positive obligation to secure to the applicants effective respect for their private life"[68].

On the same subject, there is a second case against Poland to mention.

In *R.R. v. Poland*[69], the ECtHR established once more that the lack, denial, or mistreatments suffered by a pregnant woman, who finds herself by definition in a vulnerable position, entailed a violation of Article 3 ECHR, first, and, also, of Article 8 ECHR as any decision about termination or non-termination of pregnancy is consisted with the scope and ambit of application of the right to private life.

Despite the above-mentioned cases, it should be noted, however, that, until now, the ECtHR has never admitted that there is a right to abortion as such under the ECHR[70] and, at the same time, that it continues to reject applications under the perspective of Article 14 ECHR, denying the discriminatory and gendered nature of the sufferance women and young girls are exposed[71].

In the context of abortion mistreatment, a different manifestation of obstetric and gynecological violence is represented by forced abortion.

66. *Ibidem.*

67. *Ibidem.*

68. *Ibidem*, § 112.

69. ECtHR, *R.R. v. Poland*, [Fourth Section], no. 27617/04, 26 May 2011.

70. The ECtHR's *Vo v. France* case – [Grand Chamber], no. 53924/00, 8 July 2004 – has never been challenged until now at least. On the same matter, see, also, ECtHR, *Brüggemann and Scheuten v. Germany*, [Plenary], no. 6959/75, 19 May 1976, § 61.

71. See, on this, also, ECtHR, *Tysiąc v. Poland*, §§ 136-144; ECtHR, *A, B and C v. Ireland*, [Grand Chamber], no. 25579/05, 16 December 2010, §§ 269-270.

Forced abortions are qualified as a form of violence against women under the Istanbul Convention, although there is no explicit recognition of it as a practice entailing ob-gyn violence.

A landmark case on forced abortion was delivered in 2022 by the ECtHR. In *G.M. and Others v. Moldovia*[72], the Court of Strasburg held that forced abortions and forced contraception performed to the detriment of three intellectually disabled women raped by a doctor in a neuropsychiatric residential asylum amounted to a violation of the right to inhuman and degrading treatment under Article 3 ECHR[73], taken both from the procedural and substantial perspective.

Lastly, the ECtHR had the chance to confront another typical form of ob-gyn violence, forced sterilization.

With regard to forced sterilization, there is a consistent case law now acknowledging its non-compliance with the European Convention under Article 3 and, sometimes, even jointly with Article 8 ECHR[74]. However, even in these judgments, there is nothing to indicate the existence of a link between violence and reproduction and, as a consequence, a qualification of forced sterilization as a form of obstetric and gynecological violence.

72. ECtHR, *G.M. and Others v. Moldovia*, [Second Section], no. 44394/15, 22 November 2022.

73. On this, the ECtHR stated that: "the Court finds that the existing Moldovan legal framework – which lacks the safeguard of obtaining a valid, free and prior consent for medical interventions from intellectually disabled persons, adequate criminal legislation to dissuade the practice of non-consensual medical interventions carried out on intellectually disabled persons in general and women in particular, and other mechanisms to prevent such abuse of intellectually disabled persons in general and of women in particular – falls short of the requirement inherent in the State's positive obligation to establish and apply effectively a system providing protection to women living in psychiatric institutions against serious breaches of their integrity, contrary to Article 3 of the Convention", § 128.

74. Among others, see ECtHR, *V.C. v. Slovakia*; *Y.P. v Russian Federation* (Article 3 vs. Article 8 ECHR); *Suares v. Portugal* (Article 8 ECHR); *A.P. Garçon and Nicot v. France*; *N.B. v Slovakia* (violation of Article 3 ECHR); *I.G. and Others v. Slovakia* (violation Article 8 and procedural violation of Article 3 ECHR).

6. The European Union

2024 will always be remembered as the year that saw, for the first time, the adoption by the European Union of the first Directive entirely dedicated to violence against women[75].

While it represents a significant step forward, situating the European Union in a leading position without leaving the front row to the Council of Europe, guidelines and principles on gender-based violence and domestic violence, the EU Directive nevertheless does not tackle obstetric, or gynecological violence.

Despite two references to reproduction, as access to healthcare[76], the European Union likewise falls short of addressing ob-gyn violence. It was merely recognized, as a form of violence that could rightly be covered under the umbrella of ob-gyn violence, forced sterilization, and forced abortion following the lead of the Council of Europe's Istanbul Convention.

If the European Union failed to recognize ob-gyn violence as a form of violence, in the same years it, nonetheless, showed at least more concern about women's reproductive rights. First, the proposed amendment to the EU Fundamental Rights Charter suggesting to add a new legal provision dedicated to safeguarding the right to a "safe and legal abortion".

More in tune with the implications arising out from ob-gyn violation is, instead, a non-binding document published by the European Parliament on 24th June 2021, the resolution *Sexual and Reproductive Health and Rights in the EU, in the frame of women's health*[77].

75. Directive (EU) 2024/1385 of the European Parliament and of the Council of 14 May 2024 on combating violence against women and domestic violence.

76. On this, see § 16 of the Preamble where, about forced marriages, it states that: "[f]orced marriage is a form of violence that entails serious violations of fundamental rights and, in particular, the rights of women and girls to physical integrity, freedom, autonomy, physical and mental health, sexual and reproductive health, education and a private life"; and Article 26, § 2, where the EU Directive calls the member States to "provide for victims of sexual violence to have timely access to healthcare services, including sexual and reproductive healthcare services, in accordance with national law".

77. Here's the link to the full text: *https://www.europarl.europa.eu/doceo/document/TA-9-2021-0314_EN.html*.

The Resolution builds on previous existing soft law documents on ob-gyn violence, as the 2019 Council of Europe's Committee on Equality and Non-Discrimination on obstetrical and gynecological violence and the 2019 UN Special Rapporteur for Violence Against Women's statements on ob-gyn violence.

Among the recommendations, the EU Resolution calls, the Member States "to safeguard the right of all persons, regardless of age, sex, gender, race, ethnicity, class, caste, religious affiliation and beliefs, marital or socio-economic status, disability, HIV (or STI) status, national and social origin, legal or migration status, language, sexual orientation or gender identity, to make their own informed choices concerning SRHR, to ensure the right to bodily integrity and personal autonomy, equality and non-discrimination, and to provide the necessary means to allow everyone to enjoy SRHR"[78]. In emphasizing the urge to include SRHR in the broader women's rights discourse, the Resolutions explicitly make two significant references to obstetric and gynecological violence.

In the first case, it "calls on "the Member States" to combat gynecological and obstetrical violence by reinforcing procedures that guarantee respect for free and prior informed consent and protection from inhuman and degrading treatment in healthcare settings"[79]. With the second, the Resolution recommended the member States to "do their utmost to ensure respect for women's rights and their dignity in childbirth and to strongly condemn and combat physical and verbal abuse, including gynecological and obstetric violence, as well as any other associated gender-based violence in antenatal, childbirth and postnatal care, which violate women's human rights and may constitute forms of gender-based violence"[80].

Although no definition was suggested for ob-gyn violence, the European Union has a strong commitment and a deep-rooted awareness of the challenges faced by women and girls when dealing with their bodies in the reproductive scenario.

78. See the paragraph *Forging a consensus and addressing SRHR challenges as EU challenges*, § 1.

79. See the paragraph *Sexual and reproductive health as an essential component of good health*, § 16.

80. See the paragraph *Maternity, pregnancy and birth-related care for all*, § 39.

However, not much has been done after the 2019 Resolution, as the EU Directive avoided following the lead paved by the Resolution.

Turning to soft law mechanisms, in 2024 the European Union Commission published a landmark report on *Obstetric violence in the European Union: Situational Analysis and Policy Recommendations*[81] which, nowadays, represents the most advanced and updated investigation on the state-of the-art obstetric and gynecological violence in the European Union's member States. Whether this report will contribute to the advancement of the EU's policies on violence against women in the context of SRHR is hard to say, but it should looked at as the most promising foothold for, hopefully, future EU interventions in the fields of violence against women and reproductive rights.

7. Again, in Europe, but with a Comparative Look: the States Level

Another spectrum of the analysis features the comparative investigation.

As for Europe, there are no European Union member States that has, up-to-date, adopted specific laws on ob-gyn violence yet.

The reasons behind the lack of acknowledgment of ob-gyn violence as a form of violence deserving either specific protection or, at least, to be included in the already existent legislative regulations about violence against women are complex and extremely diverse.

One among many other reasons could be identified in the somehow established separation between women's sexual and reproductive rights, on the one hand, and violence against women, on the other. The scarce reference to sexual reproductive human rights in *the* context of violence against women is, in fact, a common trait of the domestic and supranational scenario. There are either laws dealing with violence against women or concerned with regulating abortion-related issues without, at the same time, recognizing the linkages traceable between the two phenomena. This cannot be possibly explained, nor justified

81. The text of the Report, published on May 2024, can be read in full at the following link: *https://op.europa.eu/en/publication-detail/-/publication/74238fad-0b63-11ef-a251-01aa75ed71a1/language-en*.

by the dichotomy between the public and the private spheres and with the urge to preserve the latter from States' interferences, as both cases feature practices touching upon women's private life. This is why the reluctance to tackle ob-gyn violence appears utmost challenge, even though probably motivated by the difficulties in defining what could fall under the concept of ob-gyn violence and what does not.

A second critical explanation could, then, be found in the preference to cover under the umbrella of ob-gyn violence only violent practices performed against women and very young girls described as rooted in the culture or customs of a minoritarian community. This is the case for for female genital mutilation, forced sterilization, and forced abortions, which are the only forms of gynecological and obstetric violence qualified as violence against women under international human rights law and domestic law.

While there is some notable progress in the supranational scenario, the silenced approaches of European States may also be explained by their willingness to wait for supranational responses to avoid legislative fragmentation on matters where, until now, and with some notable exceptions[82], the preference has always been shown for consensual supranational responses.

Although many reasons may justify the *status quo*, the lack of protection for women suffering from ob-gyn violence should suggest that national States start adopting effective regulations to fill the gaps and loopholes of the current legislative framework of violence against women.

This is not a common history for every State across the globe and, in fact, the Latin and South American experiences especially have a lot to teach Europe both at State and supranational levels.

82. Reference is chiefly made to the cases of Spain, Sweden, Denmark and Finland. On 5 August 2022, Spain adopted the *Ley del solo sí es sí*, which is now incorporated in full the *Ley Orgánica* no. 10 of 2022, *de garantía integral de la libertad sexual*. Denmark approved a similar law For a comment on the European approach on sexual violence and consent, see S. Uhnoo, S. Erixon, M. Bladini, *The wave of consent-based rape laws in Europe*, in *International Journal of Law, Crime and Justice*, 2024. The full text can be read here: *https://www.sciencedirect.com/science/Article/pii/S175606162400020X*.

8. The "Others": Regional and Global International Organizations

Europe aside, the scenario is so widely different in the context of Latin and South America.

Since 2007, the Inter-American system as a whole and the member States altogether have been actively involved in regulating obstetric and gynecological violence, taking a lead that continues to be uncontested.

Venezuela first, in 2007, followed by Argentina, Mexico, and, more recently, Uruguay approved laws explicitly tailored to tackle obstetric and gynecological violence as a separate form of violence worth specific legislative attention.

Leaving behind the state level, which will be detailly addressed in the following contributions, the supranational system of human rights protection of the Organization of the American States likewise greatly differs compared to the regional approach of the Council of Europe.

Although the Inter-American Convention dedicated to violence against women, the so-called Belèm do Parà Convention[83], entered into force well before the CoE's Istanbul Convention, it nevertheless contains an implicit but significant reference to obstetric and gynecological violence contrasting the European approach.

Under Article 9[84], dedicated to the protection of women belonging to vulnerable communities and social groups, the Convention recognizes as in need of special protection even pregnant women. The wording is groundbreaking as, for the first time, an international human rights law treaty endorses an approach in line with the recognized connection between violence and reproduction, showing a welcome awareness

83. The full text of the Convention can be read at the following link: *https://www.oas.org/en/mesecvi/docs/BelemDoPara-ENGLISH.pdf*.

84. Article 9 reads as follows: "With respect to the adoption of the measures in this Chapter, the States Parties shall take special account of the vulnerability of women to violence by reason of among others, their race or ethnic background or their status as migrants, refugees or displaced persons. Similar consideration shall be given to women subjected to violence while pregnant or who are disabled, of minor age, elderly, socio-economically disadvantaged, affected by armed conflict or deprived of their freedom".

of the challenges faced by women, among other conditions, while carrying their children. Although it is not enough to cover all forms of ob-gyn violence, that overcome the mere condition of pregnant women, it is nonetheless remarkable the willingness to at least focus on the relationship between violent practices and health and reproductive rights. No similar provision is traceable in the Istanbul Convention, nor the newly approved EU Directive on violence against women.

The recognition of this "new" form of violence did not remain fine words.

On the contrary, the Inter-American Court of Human Rights adopted its first landmark judgment on ob-gyn violence. A landmark judgment that knows no other examples globally.

In 2023, in *Britez Arce et. al. v. Argentina*[85], the Inter-American Court of Human Rights ruled that the death of a 38-year-old pregnant woman amounted to a form of obstetric violence under the Belèm do Parà Convention.

Significantly, the Inter-American Court stated that "[w]omen have the right to live a life free of obstetric violence and [that] States should prevent it, punish it and refrain from practicing it, as well as to ensure that their agents act accordingly"[86].

This is the first time a supranational Court has used the wording "obstetric violence" to describe a practice entailing violent conduct performed to the detriment of a woman in her reproductive sphere and that and this conduct was deemed a violation the Belèm do Parà Convention. Moreover, it is likewise the first time a supranational Court identified state positive obligations to counter this peculiar form of gender-based violence. The judgment affirmed that it should be placed within the obligations of the Member States to "provide adequate, specialized and differentiated health services during pregnancy, childbirth and within a reasonable period after childbirth, to guarantee the mother's right to health and prevent maternal mortality and morbidity"[87].

Lastly, and perhaps more importantly for its extra-territorial impact, the Court provided the first legal definition of obstetric violence,

85. Inter-American Court of Human Rights, *Britez Arce et. al. v. Argentina*, 16 November 2022.

86. *Ibidem*, § 77.

87. *Ibidem*, § 62.

clarifying that, first, "obstetric violence is a form of gender-based violence […], exercised by health care providers against pregnant women, during access to health services that take place during pregnancy, childbirth and postpartum, which is expressed mostly, but not exclusively, in a dehumanizing, disrespectful, abusive or negligent treatment"[88], and, secondly, that it also may take the form of "denial of treatment and full information on the state of health and applicable treatments; in forced or coerced medical interventions; and in the tendency to pathologize natural reproductive processes, among other threatening manifestations in the context of health care during pregnancy, childbirth and postpartum"[89].

Although the proposed definition does not cover all cases of women victims of mistreatment before or in the process of becoming pregnant or during other procedures involving their reproductive health, the Inter-American Court has certainly paved the way to a true legal recognition of an unfortunately neglected form of gender-based violence.

Besides the Inter-American system of human rights, the United Nations also had something to say about discrimination against women, violence, and reproductive rights.

The first element to highlight is that the United Nations Convention on the Elimination of all Forms of Discrimination against Women features a legal provision specifically dedicated to safeguarding the right of all women to benefit from physical and mental health.

On this, the CEDAW Committee's General Recommendation No. 24 of 1999[90] on Article 12 opens by stating that "access to health care, including reproductive health is a basic right under the Convention on the Elimination of Discrimination against Women"[91]. No doubt, therefore, exists as to the commitment of the UN and the CEDAW Committee to connect women's rights to the right to health, not specifically adopting a narrower approach confined to reproduction.

88. *Ibidem*, § 81.

89. *Ibidem*.

90. Reference is to the CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health). The full text is available here: *https://www.refworld.org/legal/general/cedaw/1999/en/11953*.

91. *Ibidem*, § 1.

Among the recommendations, those that do possess a strong resonance in the endorsed perspective can be summarized as follows: to enact and effectively enforce laws and policies, "including health care protocols and hospital procedures to address violence against women and abuse of girl children and the provision of appropriate health services"[92]; to ensure gender-sensitive training for health-care workers, especially to manage the consequences arising from gender-based violence; to adopt "procedures for hearing complaints and imposing appropriate sanctions on health care professionals guilty of sexual abuse of women patients"[93]; lastly, to put into place "laws that prohibit female genital mutilation and marriage of girl children"[94].

Without explicitly using the word ob-gyn violence, the CEDAW Committee, nevertheless, makes it very clear that there is an issue to protect women in the healthcare systems against forms of violence.

However the lack of an explicit endorsement of the concept of ob-gyn violence did not prevent the CEDAW Committee from adopting its first landmark judgment on obstetric and gynecological violence.

Not surprisingly, in 2022, in *N.A.E. vs. Spain*[95], the CEDAW Committee condemned Spain in a case involving a woman subjected to excessive and unnecessary exams, medication, and other interventions without her consent during labor.

Similarly to the above-mentioned case issued against Argentina by the Inter-American Court of Human Rights, the CEDAW Committee qualified the mistreatments suffered by the woman as a form of obstetric violence, noticing that "if doctors and nurses had followed all applicable standards and protocols, it might be possible that the victim would have given birth naturally without having to go through all these procedures that left her physically and mentally traumatized"[96]

92. *Ibidem*, § 15.

93. *Ibidem.*

94. *Ibidem.*

95. CEDAW Committee, *N.A.E. vs. Spain*, No. 149/2019, 13 July 022. The full text of the judgement can be read here: *https://juris.ohchr.org/casedetails/3144/en-US.*

96. These were the words of the member of the CEDAW Committee Hiroko Akizuki.

and, more importantly, that "States parties must take all appropriate measures to modify or abolish not only existing laws and regulations but also customs and practices that constitute obstetric violence"[97].

In short, the CEDAW Convention member states, regardless of the silent approach of the Istanbul Convention on the European scenario, must tackle ob-gyn violence as a positive obligation as it has been formally recognized under international human rights law.

9. When Intersectionality Comes and Plays: Forced Sterilizations

There are other cases where violence against women and reproductive rights intertwine with one another. Women belonging to ethnic minorities and marginalized communities are exposed to a wider range of conducts that possess similar traits to those qualified as forms of obstetric and gynecological violence.

In other words, intersectionality impacts ob-gyn violence and contributes to its ways of manifestation. So-called "minority women"[98], as double minorities[99] within already stigmatized social groups are, therefore, exposed to many different forms of violent conduct affecting their fundamental rights. Including those involving their reproductive sphere.

A first example is represented by discriminatory national laws or domestic customary practices, that, often, include spousal or third-party consent for allowing women to access medical treatments. Secondly,

97. *Ibidem*, § 15.8.

98. With the concept "minority women", we refer to women affiliated to already marginalized communities divided by the majority according to ethnic, racial, religious, linguistic or cultural lines. On this, see A.S. Spiliopoulou, *Human Rights of Minority Women: A Manual of International Law*, Turku: Åland Åbo Akademi University Institute for Human Rights, 2000; A. Xanthaki, *Women's Rights v. Cultural Rights: The Indigenous Woman*, in *Diritti umani e diritto internazionale*, 2018, 359 ss.; see, also, C. Nardocci, *Minority Women, Human Rights, and Cultures in the Multicultural Discourse*, in Fornalé, E., Cristani, F. (eds.), *Women's Empowerment and Its Limits*, Palgrave Macmillan, Cham., 2023, 53 ff.

99. On the concept of "double minorities", see, extensively, L Green, *Internal Minorities and Their Rights*, University of Toronto Press, Toronto, 1992.

practices like forced sterilizations and forced abortions, continue to disproportionately affect women belonging to minorities much more than women affiliated to the dominant group. Similar, in terms of the major exposure of minority women, are female genital mutilations, which, again, see minority women and girls more exposed.

Unfortunately, none of the above-mentioned forms of violence are interpreted as forms of ob-gyn and obstetric violence in Europe, nor under the Istanbul Convention, which significantly avoids using the term ob-gyn violence[100].

Forced sterilizations represent a good example of unraveling the relationship between ob-gyn violence, intersectionality, and the minority discourse. The victims of forced sterilizations are predominantly, in fact, disabled women, Roma women, refugee women, rural women, and indigenous women. All cases where it is not just being a woman that features the ideal type of women, but, rather, it's the intersection with social condition, race, ethnicity, and national origin.

The neglected recognition of forced sterilizations as forms of ob-gyn violence, on the one hand, but its recognition (at least!) as a manifestation of gender-based violence at the Council of Europe level, on the other, is reflected in the lack of consensual legislative responses in the European Union.

Across the European Union member States, 14 do not allow forced sterilizations[101] and only 9 formally prohibit the practice under the law[102].

There are also EU member States, that permit forcibly sterilization of minors[103] and of people with disabilities[104].

Besides the EU Member States that have chosen to allow forced sterilization, the criminalization of the practice at issue does not always entail its effective contrast. This is what happens, just to mention some,

100. Interestingly, the Rome Statute of the International Criminal Court qualifies forced sterilization as a crime against humanity.

101. These are: Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Hungary, Latvia, Lithuania, France, Portugal and Slovakia, Sweden until 1976 for racist motives.

102. One example is Spain.

103. Czech Republic, Hungary, and Portugal.

104. France.

in the Check Republic and Slovakia that resort to criminal law to sanction the practice, that, however, persists at highly severe rates.

Outside the European Union, forced sterilizations also persist as a birth control mechanism. In Perú, indigenous, rural, and undereducated women may be exposed to forced sterilization practices. In China, forced sterilization is used against minoritarian communities like Uighurs and other minorities to curb the Muslim population. Lastly, in the United States, 31 States, including Washington, D.C., allow to some extent the forced sterilization of women with disability.

Beyond the legislative framework, which would deserve a more in-depth analysis which goes well beyond the scope of the Article, and the limited ECtHR's case law mentioned above, other supranational Courts had something to say about forced sterilizations.

Landmark judgments have been issued over the last few years, especially by the Inter-American Court of Human Rights. In *Maria Mamerita Mestanza Chavez v. Peru*[105], the Inter-American Court of Human Rights condemned Perú for the death of a woman, who had been forcibly sterilized without her prior consent. Similar conclusions were found in another case, *I.V. v. Bolivia*[106], which concerned this time the subjection of a woman to surgical sterilization without her prior informed consent.

More recently, the Inter-American Commission on Human Rights (IACHR) submitted another interesting case to the Inter-American Court of Human Rights, about a woman, *Celia Edith Ramos Durand*, who died following a forced and not consensual sterilization performed as part of the Peruvian National Reproductive Health and Family Planning Program[107]. This will be the first case of forced sterilization

105. Inter-American Commission on Human Rights, Report No. 66/00, Case 12.191, October 3, 2000; OEA/Ser./L/V/II.111, doc. 20 rev., 16 April 2001.

106. Inter-American Commission on Human Rights, Report No. 40/08, Petition 270-07, July 23, 2008; OEA/Ser.L/V/II.134, Doc. 5, rev. 1, 25 February 2009.

107. The news can be read at the following link: *https://www.oas.org/en/iachr/jsForm/?File=/en/iachr/media_center/preleases/2023/186.asp*. Accordingly to news report, between 1996 and 2001, Peru's National Reproductive Health and Family Planning Program sterilized 272,028 women and 22,004 men.

performed during the Peruvian *Fujimori Regime*, which conducted a structural policy of forced sterilization, especially of rural and indigenous women despite the unheard critics of the United Nations in the past decades[108]. If the Inter-American Court of Human Rights ends up with a finding of a violation, the judgment will represent the first case of reparation, opening hopefully the doors to a broader compensation for the more than thousands of victims of forced sterilization in Perú.

10. Including Ob-Gyn Violence in the Women's Rights Discourse, Challenges and How to

As there is no consensus about what ob-gyn violence is or implies for women and their fundamental rights, similarly the European scenario features a general lack of understanding of this form of violence which brings several consequences.

The first is the absence of a true and shared acknowledgment that women and young girls could be exposed to violence, in contexts where they are supposed to be treated and gain beneficial support for their health and well-being.

The second is the neglected identification of healthcare workers as – sometimes, of course, intentionally – perpetrators of forms of violence. Despite cases of intentional harm as it could be for FGMs, forced sterilizations, and forced abortions for reasons related to genetic selection or racist motives, there is a fine line between the concept of violence used for example under the Istanbul Convention and worldwide, and a possible liability for malpractice. The point is, therefore, where we agree on tracing the boundaries between malpractice *per se* and Ob-gyn violence, on the one hand, and between malpractice, and intentional

This according to El Pais, see the following link: *https://english.elpais.com/international/2023-09-28/victims-of-forced-sterilization-in-peru-take-their-case-to-the-inter-american-court-of-human-rights.html*.

108. Reference is made to the conclusions of the ICCPR Committee on Perú that underlined that "[d]espite the significant number of years that have elapsed, the victims have still not received reparation, and the perpetrators have not been sanctioned".

acts that cannot be considered as pure malpractice due to their strong resemblance with violence against women.

The major challenge is, therefore, not much covering under the umbrella term of ob-gyn violence practices already defined as gender-based violence, although not yet defined (FGMs, forced sterilizations, forced abortion). Rather, the point is how to argue the qualification as forms of ob-Gyn violence of the much wider categories of conducts and practices undertaken by healthcare workers while performing their duties.

Beyond ethical and societal reasons, the difficulties in looking at healthcare workers as perpetrators are also connected to another trait of gender-based violence that could be sometimes lacking in cases of ob-gyn violence. Intentionality. Not every time, not every conduct that could yet be interpreted as a form of ob-gyn violence is international and this aspect could play a key element in shaping the definition of ob-gyn violence and in establishing civil or criminal liability.

Looking at Europe, the above investigation suggests that the inclusion of ob-gyn violence in the gender-based violence discourse could be supported by a more robust protection of reproductive rights.

That is to say that the debate surrounding the amendment of the EU Charter of Fundamental Rights to explicitly safeguard the right to safe and legal abortion should be supported and seen also as a way to boost the recognition of ob-gyn violence. However, as widely known, the safeguard of the right to a safe and legal abortion is still controversial. Poland adopted one of most strict laws on abortion and the anti-abortion movement in Eastern Europe is particularly strong. On the other side, there is France, recently successful in including the right to abortion in its own Constitution. The East-West EU divide is not expected to play out in favor of an EU action towards the formal recognition of ob-gyn violence under the existing legislative framework.

Beyond the argument that the path toward recognizing the right to abortion may both benefit from and eventually intersect with the fight against ob-gyn violence, it is still possible – and indeed necessary – to offer some non-country-specific suggestions to keep the discussion open and evolving. First, it would be advisable, as said already, to interlace reproductive rights with violence against women as a way

to favor the inclusion under the latter of cases of violations of the former. The second could be to subsequently endorse an evolutive interpretation of ob-gyn and violence to cover: acts performed outside hospitals as well as conducts featured on a customary and/or traditional basis.

A third recommendation lies in the need to envision approaches to ob-gyn and obstetric violence, that take intersectionality and the statuses of minority women seriously.

Lastly, it is increasingly important – especially considering the potential impact of AI systems in healthcare – not to underestimate the connection between ob-gyn violence and racism. Historical and ongoing cases of forced sterilizations targeting women from racial and ethnic minorities across the globe highlight how these abuses are not confined to the past but continue in various forms today.

Addressing Obstetric and Gynecological Violence. Legal Perspectives from Venezuela and Mexico

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Summary: 1. An overview of the dimensions of Obstetric and Gynecological Violence – 2. ObGyn violence in Venezuela: a legal response to a gender-based discrimination – 3. The regulatory humanization of childbirth in Mexico – 4. Concluding considerations.

1. An overview of the dimensions of Obstetric and Gynecological Violence

The issue of women's dignity and health is, among other things, relevant in the field of childbirth and maternity care. Excessive and unjustified interference in the reproductive health of women, often justified by paternalism still present in delivery rooms, requires a legal reflection on how to address issues that significantly violate women's rights. The legal debate of the past decade has focused on the possibility of creating specific legal provisions to define obstetric and gynecological violence as a particular form of gender-based violence.

The concept of violence was first associated with childbirth in 1994 within the framework of the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (the Belém do Pará Convention). In this legal document, Article 2 included childbirth assistance as part of various forms of gender-based violence that cause physical, sexual, or psychological harm to women (Article 1)[1].

1. Subsequently, the Convention on the Elimination of All Forms of

In 2007, Venezuela became the first country to translate these principles into national law with the *Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia*, paving the way for other countries in Latin America and around the world to recognize such forms of violence associated with childbirth and pregnancy.

In 2014, the World Health Organization, through the statement *The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth*, documented how a significant number of women worldwide suffer abuse in both public and private healthcare facilities during childbirth[2]. The WHO identified the elements of such abuse, including the lack of privacy, inadequate informed consent (often insufficient), physical abuse, and the imposition of non-consensual or inappropriate medical procedures that failing to guarantee the full protection of women's health[3]. The WHO's goal

Discrimination Against Women (CEDAW), adopted in 1979 by the United Nations General Assembly, included, with Recommendation No. 35 – updating the previous Recommendation No. 19 – maternity and health status among the factors that can give rise to manifestations of gender-based violence.

2. As for Europe, in 2017, in an Issue Paper, the Council of Europe emphasized the persistence, in various areas of Europe, of a failure to guarantee adequate standards of care and respect for women's rights, dignity, and autonomy during childbirth assistance. At the same time, it highlighted that it is the responsibility of each state to ensure the rights of women and promote their equality. For this reason, in 2019, the Resolution of the Parliamentary Assembly of the Council of Europe on Obstetric and Gynecological Violence (Resolution 2306 (2019) of the Parliamentary Assembly of the Council of Europe, adopted on October 3, 2019) was adopted, which defines obstetric violence "*a violation of human rights and a manifestation of gender discrimination*"; "*a form of violence that has long been hidden and is still too often ignored*"; adding: "*This violence reflects a patriarchal culture that is still dominant in society, including in the medical field*". The European Parliament Resolution on the situation of sexual and reproductive health and rights in the EU within the framework of women's health (2021), which frames gynecological and obstetric violence as forms of abuse and discrimination in the area of sexual and reproductive health (Recital, letter I) and violations of human rights motivated by gender-based hatred (paragraphs 16 and 41).

3. On the issue, see S.Z.M. Cipolla, *La posizione della partoriente come misura del grado di medicalizzazione del parto: ricostruzione storica e prospettive odierne*, in *BioLaw Journal*, 2/2022, which – by retracing the history of maternity and

was twofold: on one hand, to promote a more "humane" approach to childbirth that respects women's rights by recognizing their central role in the planning and management of childbirth, with adequate information provided to them; and on the other hand, to denounce the negative impact of an overly medicalized approach that transforms childbirth into an inherently risky event, even in normal physiological conditions[4].

The notion of *obstetric and gynecological violence*[5] therefore encompasses all practices that violate the dignity and health of women in the context of maternity and childbirth — from the absence of informed consent to medical procedures that fail to ensure the safety of women in the medical and gynecological field, thus limiting their right to health and dignity. Furthermore, alongside the "normal" deficiencies in care typical of delivery rooms — such as the failure to call the anesthesiologist or gynecologist by the obstetric staff, the violation of the parturient's privacy, and the omission of information about the newborn's health[6] — there are also dismissive comments, misogynistic and paternalistic attitudes, insults, and other forms of

childbirth - highlights how, at least initially, childbirth represented for women a moment of rupture with the hierarchical dependence on men, as they were not involved in the childbirth process and were instead replaced by other women (midwives or female companions). In this way, childbirth became a moment in which women asserted their generative power through the free use of their bodies during the birth event. However, later, in the process of disciplining women within marriage, the mystery and taboo surrounding pregnancy were slowly emptied and removed by medical knowledge. See also M. Del Priore*, Ao sul do corpo, cão feminina, maternidades e mentalidades no Brasil colónia*, San Paolo, 1990, 228.

4. M. Vuille, *Demedicalizzare la nascita? Considerazioni storico sociali su un'espressione polisemica*, in *Antropologia*, 12, 2010, 61 ss.

5. On the origins of the notion of obstetric violence, see R. Van der Waal, K. Mayra, A. Horn, R. Chadwick, *Obstetric Violence: An Intersectional Refraction through Abolition Feminism*, in *Feminist Antrhopology*, 4, 2023; P. Quattrocchi, *Obstetric Violence Observatory: Contributions of Argentina to the International Debate* in *MedicalAnthropology: Cross-Cultural Studies in Health and Illness*, 2019.

6. M. Di Lello Finuoli, *Profili penali della c.d. violenza ostetrica*, *in Sistema penale*, 6.

disrespect, directly linked to the perception of women's ability to manage childbirth and endure pain[7].

The phenomenon of obstetric violence is not limited to acts that harm the autonomy of parturients during childbirth assistance; it also encompasses any other disrespectful or abusive behavior by medical, obstetric, nursing, and social healthcare staff toward women during labor, childbirth, and the provision of healthcare services related to sexual and reproductive health, such as gynecological visits, abortion procedures, medically assisted reproduction, breastfeeding consultations, and contraceptive prescriptions[8]. Indeed, the prevailing paradigm is the technicization and medicalization of institutionalized childbirth care, which sees the birthing woman as an "object" of intervention rather than a "subject" of rights[9].

However, this form of violence often remains invisible, deeply socially and culturally legitimized[10]. This legitimization, rooted in stereotypes and consolidated practices, alters the perception of violence by both parties in the relationship, often making it difficult to identify and counteract — that is, for one party to recognize they are suffering violence and the other to realize they are perpetrating it[11]. The asymmetric relationship between women and healthcare professionals reveals an inequality, both symbolic and real, that often makes it difficult for women to exercise their fundamental rights[12].

The Venezuelan and Mexican experiences, which will be the subject of this contribution, offer significant insights into understanding the scope of this issue, as well as analyzing the normative and jurisprudential

7. M.A. Bohren *et al.*, *The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review*, in *Plos Medicine*, 2015.

8. M. Di Lello Finuoli, *Profili penali della c.d. violenza ostetrica*, cit., pp. 1-2.

9. L.F. Belli, *La violencia obstétrica: otra forma de violación a los derechos humanos*, in *Revista Redbioética/UNESCO*, Año 4, 1 (7), 27.

10. C. Cannone, *La violenza in sala parto. Osservazioni a margine di una questione controversa*, in *Studi sulla questione criminale*, 1-2/2019, 154.

11. M. Sadler *et al.*, *Moving beyond disrespect and abuse: Addressing the structural dimensions of obstetric violence*, *in Reproductive Healt Matters*, 2016, 47 ss.

12. L.F. Belli, *La violencia obstétrica*, cit., 28.

responses. Specifically, this paper will explore how these legal systems have addressed the phenomenon of obstetric violence in an attempt to define the boundaries of this form of violence and the responses from legal frameworks: defining the dimensions of obstetric violence will help highlight the general lack of awareness about childbirth issues and confront the challenges related to health and knowledge for all involved[13].

2. ObGyn violence in Venezuela: a legal response to a gender-based discrimination

Latin American legislative interventions regarding obstetric violence are part of a broader reform movement that, since the 1970s, has manifested as a global movement for the humanization of childbirth. This movement has gained particular relevance in recent decades, with a significant turning point at the end of the last century. A key event for this movement was the first international conference on the Humanization of Childbirth, held in Brazil in 2000. During this event, a group of Latin American activists, researchers, and healthcare professionals gathered to address the high rate of unnecessary interventions during childbirth and the growing recognition of the abuse many women experience during the birthing process. In this context, the RELACAHUPAN network (Latin American and Caribbean Network for the Humanization of Childbirth) was formed, which has played a crucial role in promoting and spreading the debate

13. C. Cannone, *La violenza in sala parto*, cit., 155 ss. The author also refers to the debate between feminist organizations and those of gynecologists; a confrontation between those who believe that obstetric violence lies at the crossroads of institutional violence and gender-based violence. On one hand, it would constitute a violation of women's fundamental rights and freedoms in the area of reproductive health – such as the right not to be discriminated against, the right to accurate information, physical and mental integrity, and reproductive autonomy – as well as an expression of power inequalities between men and women. On the other hand, gynecological associations reject any cultural and normative recognition of a conceptual category like obstetric violence.

on women's rights to a respectful and dignified birth, contributing to the formulation of regulations that protect the dignity and autonomy of women during childbirth.

The evolution of anthropological studies on the causes and manifestations of violence in gynecological and obstetric contexts has led various Central American countries to legally define obstetric violence, introducing sanctions for more severe forms of aggression against the liberty and dignity of the women involved.

As previously mentioned, Venezuela was the first country to legally define obstetric and gynecological violence[14]. Through the *Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia* in 2007, Venezuela defined obstetric violence in Article 15 as follows: "*Se entiende por violencia obstétrica la apropiación del cuerpo y procesos reproductivos de las mujeres por personal de salud, que se expresa en un trato deshumanizador, en un abuso de medicalización y patologización de los procesos naturales, trayendo consigo pérdida de autonomía y capacidad de decidir libremente sobre sus cuerpos y sexualidad, impactando negativamente en la calidad de vida de las mujeres*"[15].

Furthermore, Article 51 (*Violencia Obstétrica*)[16] of the *Ley Orgánica*

14. On the subject, see A. Villegas Poljak, *La violencia obstétrica y la esterilización forzada frente al discurso médico*, in *Revista Venezolana de Estudios de la Mujer*, n. 32, 2009; D.J. Faneite, A. Feo, J. Toro Merlo*, Grado de conocimiento de violencia obstétrica por el personal de salud*, in *Rev Obstet Ginecol Venez*., n. 1, 2012; L.I. Diaz, Garcia, Y. Fernandez M., *Situación legislativa de la Violencia obstétrica en América latina: el caso de Venezuela, Argentina, México y Chile*, in *Revista de Derecho de la Pontificia Universidad Católica de Valparaíso,* no. 51, 2018.

15. *Obstetric violence is understood as the appropriation of the body and reproductive processes of women by health personnel, expressed in dehumanizing treatment, in the abuse of medicalization and pathologization of natural processes, leading to a loss of autonomy and the ability to freely decide over their bodies and sexuality, negatively impacting women's quality of life.*

16. Art. 51. *Violencia obstétrica. Se considerarán actos constitutivos de violencia obstétrica los ejecutados por el personal de salud, consistentes en: 1. No atender oportuna y eficazmente las emergencias obstétricas. 2. Obligar a la mujer a parir en posición supina y con las piernas levantadas, existiendo los medios necesarios para la realización del parto vertical. 3. Obstaculizar el apego precoz del niño o niña con su madre, sin causa médica justificada, negándole la posibilidad de cargarlo o cargarla y*

provides a specific legal framework for identifying obstetric violence, outlining specific behaviors attributable to healthcare personnel that violate the rights of women during childbirth. It is in the Venezuelan context that the term *"obstetric violence"* was coined for the first time, designating this form of violence as the appropriation of women's bodies and reproductive processes by medical and healthcare staff, representing a process of dehumanization and the medicalization and pathologization of natural processes.

The *Ley Orgánica* specifies several acts that constitute obstetric violence. Among these is the failure to provide timely and effective intervention in obstetric emergencies, a factor that severely compromises a woman's right to adequate healthcare. For example, it is considered obstetric violence to force a woman to give birth in a supine position with her legs elevated when means are available to allow for a vertical birth, a practice recognized as more respectful of the physiological needs and preferences of the birthing woman. Similarly, the *Ley Orgánica* qualifies as obstetric violence the unjustified use of techniques to accelerate childbirth in low-risk situations when these are performed without the woman's free, informed, and explicit consent. Finally, Article 51 includes as another component of obstetric violence the obstruction of early bonding between mother and newborn, which occurs when, without medical justification, the mother is denied the opportunity to hold or breastfeed her newborn immediately after childbirth[17].

amamantarlo o amamantarla inmediatamente al nacer. 4. Alterar el proceso natural del parto de bajo riesgo, mediante el uso de técnicas de aceleración, sin obtener el consentimiento voluntario, expreso e informado de la mujer. 5. Practicar el parto por vía de cesárea, existiendo condiciones para el parto natural, sin obtener el consentimiento voluntario, expreso e informado de la mujer. En tales supuestos, el tribunal impondrá al responsable o la responsable, una multa de doscientas cincuenta (250 U.T.) a quinientas unidades tributarias (500 U.T.), debiendo remitir copia certificada de la sentencia condenatoria definitivamente firme al respectivo colegio profesional o institución gremial, a los fines del procedimiento disciplinario que corresponda.

17. The law provides for the imposition of a financial penalty ranging from 250 to 500 tax units (UT) for the responsible parties. Furthermore, it stipulates that a certified copy of the final judgment be sent to the professional association or the

The behaviors that fall under the notion of obstetric violence are, therefore, diverse, mainly comprising verbal abuse, physical violence, and violations of consent or abuses of authority[18]. Additionally, reference is made to forced sterilization, firstly in Article 15, which specify that "*Se entiende por esterilización forzada, realizar o causar intencionalmente a la mujer, sin brindarle la debida información, sin su consentimiento voluntario e informado y sin que la misma haya tenido justificación, un tratamiento médico o quirúrgico u otro acto que tenga como resultado su esterilización o la privación de su capacidad biológica y reproductiva*"[19]. Forced sterilization is specifically regulated in Article 52, which stipulates that anyone who intentionally deprives a woman of her reproductive capacity without providing adequate information or obtaining explicit, voluntary, and informed consent, without a medically or surgically justified reason, is punishable by imprisonment.

In this framework, despite the Venezuelan law introducing a broad legal provision without specifying all possible situations of dehumanizing treatment or abuse of medicalization, it identifies three main areas of application of the norm: disrespectful or dehumanizing treatment; the common practice of over-medicalization; and the pathologization of the event; and the expropriation of the birth process by healthcare personnel, depriving the woman of centrality and decision-making autonomy. In this sense, what this law does is firmly position the definition within the discourse (and practice) of gender equality and women's sexual and reproductive rights, as well as specifying who the perpetrators of this violence are in this context.[20].

institution to which the convicted healthcare personnel belong, in order to initiate the corresponding disciplinary procedure..

18. M. Di Lello Finuoli, *Profili penali della c.d. violenza ostetrica*, cit., p. 12.

19. Forced sterilization is understood as intentionally performing or causing a medical or surgical treatment, or any other act that results in sterilization or the deprivation of a woman's biological and reproductive capacity, without providing her with the necessary information, without her voluntary and informed consent, and without any justification for the procedure.

20. P. Sesia, *Violencia obstétrica en Mexico: La consolidación disputada de un nuevo paradigma*, in P. Quattrocchi, N. Magnone (eds.), *Violencia obstétrica en America Latina. Conceptualización, experiencias, medición y estrategias*, EDUNLa Cooperativa, 2020, 6.

Therefore, Venezuelan legislation plays an innovative and pioneering role by recognizing and sanctioning practices that violate the autonomy, dignity, and health of women during one of the most crucial moments of their lives. Indeed, obstetric violence is globally recognized as a violation of human rights. Article 3 of the *Ley Orgánica* lists the rights violated by various forms of violence against women. Among these are the right to life – encompassing the right not to die from preventable causes related to childbirth and pregnancy (Article 43, CRBV) – as well as the right to protection of dignity and physical, psychological, sexual, patrimonial, and legal integrity, and gender equality.

Alongside these rights, it is important to emphasize reproductive rights, such as the right to freedom, personal safety, and integrity, the right to privacy, the right to adequate and timely information, and, of course, the right to women's health[21]. The existence of the fundamental right to health obliges states to ensure the protection of their citizens so that they can live under conditions that include free access to healthcare. This would simultaneously guarantee, as intrinsically connected, the protection of the right to life and the right to dignity.

Drawing from constitutional provisions, obstetric violence represents a significant violation of the principle of non-discrimination, enshrined in Article 21 of the Venezuelan Constitution, as well as the dignity and physical and psychological integrity of women, recognized as fundamental constitutional rights under Articles 43 and 75 of the Constitution.

3. The regulatory humanization of childbirth in Mexico

The legislative intervention in Venezuela, aimed at promoting greater "humanization" of childbirth - partly in response to pressure from social movements - has laid the foundation for subsequent regulatory developments in other Latin American countries. Among these is Mexico, which, in 2007, adopted the *Ley General de Acceso de las Mujeres a una Vida Libre de Violencia*, later reformed in 2022.

21. M. Villaverde, *Salud Sexual y Procreación Responsable*, in *Jurisprudencia Argentina*, 2006, 31-32 ss.

This federal law addresses, among other issues, the phenomenon of obstetric violence, emphasizing its roots in patriarchal domination within healthcare institutions. Obstetric violence is defined as "any action or omission by medical and healthcare personnel that harms, injures, demeans, or causes the death of a woman during pregnancy, childbirth, or the postpartum period".

Obstetric violence is rooted in two main factors: on the one hand, the dominance of a biomedical model that undervalues the emotional and social aspects of health, and on the other, its connection to gender-based violence as an expression of a patriarchal society[22]. Obstetric violence is a "polysemic" concept[23], describing a form of institutional violence perpetrated by the state within healthcare services through direct actions, omissions, or lack of protection. This type of violence reflects patriarchal power dynamics, legitimizing the appropriation of women's bodies and the natural processes of pregnancy and childbirth. It manifests through dehumanizing treatment, excessive medicalization, and pathologization, leading to a loss of autonomy and decision-making power for women.

Institutional violence, in this sense, encompasses the set of institutional norms and procedures, as well as acts and omissions by public services, that result in both gender-based harm and stereotypical social and cultural behaviors or practices based on the idea of women's inferiority and subordination to men[24].

Obstetric violence is often invisible and extends beyond care during pregnancy and childbirth, encompassing other aspects of sexual health. It represents a model of control and subordination

22. P. Sesia, *Violencia obstétrica en Mexico: La consolidación disputada de un nuevo paradigma*, cit., 8 ss.

23. G.B. Muñoz Garcia, L.R. Berrio Palomo, *Violencias más allá del espacio clínico y rutas de la inconformidad: La violencia obstétrica e institucional en la vida de mujeres urbanas e indígenas en México*, in P. Quattrocchi, N. Magnone (eds.), *Violencia obstétrica en America Latina*, cit., 104.

24. In general, on the theme of the historical inferiority of women, see E. Cantarella, *L'ambiguo malanno. Condizione e immagine della donna nell'antichità greca e romana*, Feltrinelli, 2013; M. D'Amico, *Una parità ambigua. Costituzione e diritti delle donne*, Raffaello Cortina Editore, 2020.

imposed on women's bodies, denying them autonomy and informed decision-making[25].

The primary victims of obstetric violence are women, directly affected during childbirth and reproductive processes. However, this phenomenon may also impact women's family members, who endure the emotional consequences of the abuse, and medical and healthcare personnel - particularly midwives - when coerced to operate under inadequate or restrictive conditions.

A 2016 study revealed significant percentages of Mexican women who experienced harm and violence during childbirth and pregnancy. Among women who gave birth in the previous five years, 43% underwent cesarean sections, but about 10% reported not being adequately informed or not consenting to the procedure. Verbal abuse (11.2%), delays in care (10.3%), and denial of anesthesia without explanation (5%) were common. Nearly 9% of women reported being coerced into contraceptive procedures without their consent or adequate information[26].

In Mexico, the regulation of obstetric violence operates on two levels: federal and state. At the federal level, the 2007 *Ley General de Acceso de las Mujeres a una Vida Libre de Violencia* aims to prevent, punish, and eliminate violence against women. Although this law does not directly address obstetric violence, some provisions can be interpreted to offer indirect protection. Article 1 of the federal law seeks to establish coordination among the Federation, federative entities, territorial demarcations of Mexico City, and municipalities to prevent, punish, and eliminate violence against women, adolescents, and girls while promoting access to a life free from violence and ensuring full enjoyment of human rights.

Article 6 of the law identifies various forms of violence against women, including psychological, physical, patrimonial, economic, sexual and other analogous forms that harm or are likely to harm women's dignity, integrity, and freedom. The broad scope of Article 6,

25. G.B. Muñoz Garcia, L.R. Berrio Palomo, *Violencias más allá del espacio clínico y rutas de la inconformidad*, cit., 105 ss.

26. Encuesta Nacional sobra la Dinamica de las Relaciones en los Hogares, 2016.

combined with Article 18 - relating to institutional violence[27] - allows for the inclusion of obstetric violence within the normative framework, even though it is not explicitly typified as a specific offense, as has been done in Venezuela.

In 2022, a reform of the *Ley General de Salud* and the *Ley General de Acceso de las Mujeres a una Vida Libre de Violencia* introduced specific provisions on obstetric violence, explicitly recognizing it as a form of violence against women. Among the new regulations, the reform of Article 46, sections I and XI, stands out, as it introduced a new chapter titled "On Obstetric Violence", which includes Article 20-*septies*. Addressing the reality that 33 out of 100 women report being mistreated during childbirth, the reform recognizes as obstetric violence the unwarranted practice of cesarean sections or contraceptive methods without the informed consent of the affected individuals.

At the state level, only some of the 31 federal entities in Mexico have introduced specific regulations on obstetric violence[28]. Among the first to legislate on the issue, Veracruz and Chiapas enacted laws in 2008 and 2009, respectively, inspired by the Venezuelan model. Both federal entities focused their legislation on safeguarding women's decision-making autonomy in matters related to reproductive health. Across all states, the concept of obstetric violence is similar, and, echoing the Venezuelan definition, it is linked to the appropriation of women's bodies and reproductive processes by healthcare personnel. This manifests in dehumanizing treatment, the overuse of medicalization, and the pathologization of natural processes, resulting in a loss of women's autonomy and decision-making capacity regarding their bodies and sexuality.

The Mexican healthcare system faces significant structural deficiencies, including a lack of equipment, qualified personnel,

27. Institutional violence is defined as acts or omissions by public servants of any level of government that discriminate, use gender stereotypes, or aim to delay, obstruct, or prevent the enjoyment and exercise of women's human rights, as well as their access to the benefits of public policies designed to prevent, address, investigate, sanction, and eradicate the different types of violence.

28. Grupo de Información en Reproducción Elegida (GIRE), *Omisión e indiferencia. Derechos reproductivos en México* (México D.F., 2013), 46.

and financial resources. These deficiencies lead to overcrowded public hospitals and stark inequalities in access to care, exacerbated by inadequate information and insufficiently trained staff[29]. These challenges are most pronounced in poorer and marginalized states, as well as rural and Indigenous areas[30]. Here, difficulties have worsened since the decentralization of the healthcare system in 2017[31]. This has led to an increase in unnecessary obstetric interventions, such as unwarranted cesarean sections, and the consolidation of invasive, painful, dehumanizing, and harmful obstetric practices[32] that violate both national regulations and international guidelines.

It is important to note that available data may not fully reflect reality, as many women in Mexico are unaware of their rights and do not receive adequate information. Moreover, the normalization of abusive and hyper-medicalized hospital practices makes it difficult for women to recognize and report incidents of obstetric violence[33].

Scholars argue that medical authoritarianism is also rooted in gender inequality. It has been observed that even when institutions resolve disputes over reproductive health rights, they often perpetuate the same gendered order they aim to transform[34]. Scholars propose

29. E. Lazcano, R. Schiavon, P. Uribe, D. Walker, L. Suárez-López, L. Luna-Gordillo, A. Ulloa-Aguirre, *Cobertura de atención del parto en México. Su interpretación en el contexto de la mortalidad materna. Salud Pública de México*, n. 2, 2013, 214-224.

30. P. Sesia, M. García, N. García, G. Carmona, M. Sachse, *Resultados del monitoreo de las redes de servicios de salud materna del estado de Oaxaca* in G. Freyermuth, P. Sesia (ed. by*), Monitoreos, diagnósticos y evaluaciones en salud materna y reproductiva: Nuevas experiencias de contraloría social*, México, CIESAS, 2013, 149-179.

31. P. Sesia, *Violencia obstétrica en Mexico*, cit., 9.

32. DeMaria *et al*., 2012; Sachse *et al*., 2012, Sachse, Sesia & García, 2013; Smith-Oka, 2013; Valdez-Santiago *et al*., 2013, Walker *et al*., 2011.

33. P. Sesia, *Violencia obstétrica en Mexico*, cit., 10.

34. R. Castro, J. Erviti, *Sociología de la práctica médica autoritaria: Violencia obstétrica, anticoncepción inducida y derechos reproductivos*, Centro Regional de Investigaciones Multidisciplinarias, Universidad Nacional Autónoma de México, 2015. See also, R. Castro, *Génesis y práctica del habitus médico autoritario en México* in *Revista Mexicana de Sociología*, 2014, 167 ss.

analyzing obstetric violence through an integrated model that connects its various dimensions. These forms of obstetric violence cannot be fully understood without considering the systemic and cultural structures that perpetuate women's subordination[35]. These structures directly influence the treatment of women in healthcare and reproductive contexts, contributing to the consolidation of discriminatory practices.

4. Concluding considerations

In light of the above discussion, it is now possible to draw some concluding considerations. The experiences of Venezuela and Mexico confirm that the "core element" of obstetric violence lies in physical, psychological, and verbal mistreatment of women (not limited to pregnant or birthing women). This mistreatment includes forms of disrespect toward women, encompassing their bodies, cultures, and privacy, as well as restrictions on their autonomy and freedom of choice[36].

In most cases, obstetric violence manifests during childbirth assistance or other therapeutic procedures related to sexual and reproductive health provided by healthcare facilities. It is perpetrated by healthcare and social care professionals, including specialized doctors or medical trainees in obstetrics, anesthesiology, nurses, midwives, and even volunteers. The central aspect that distinguishes and characterizes obstetric violence is the relationship between a woman's self-determination and decision-making autonomy and the professional freedom of healthcare personnel.

An interesting aspect concerns the framing of obstetric and gynecological violence within the broader context of gender-based violence[37]. A common thread in the Latin American experiences is the

35. R. Castro, S.M. Frias, *Violencia obstétrica en México: hallazgos de una encuesta nacional de violencia contra mujeres*, in P. Quattrocchi, N. Magnone (eds.), *Violencia obstétrica en America Latina,* cit., 72.

36. P. Quattrocchi, *Violenza ostetrica. Le potenzialità politico-formative di un concetto innovativo*, in *EtnoAntropologia*, 7, 2019, 138-139.

37. Indeed, a portion of these abuses stems from the pathological distortion

classification of obstetric violence as a form of gender-based violence - that is, violence perpetrated against women because they are women. The element of gender thus plays a fundamental role in defining behaviors that fall within the concept of obstetric violence, as well as in shaping legal responses to the phenomenon.

The concept of obstetric violence is rooted in three key gendered dynamics: the impact of gender inequalities on women's exclusive role in childbirth, the framing of childbirth as a medical event that diminishes women's reproductive agency, and the power imbalance between healthcare professionals and birthing women. These factors underscore the systemic, gendered, and sexist nature of obstetric violence, shaped by interactions between cultural and healthcare systems[38].

However, the Venezuelan and especially the Mexican experiences highlight that obstetric violence should not only be considered a form of gender-based violence but also as institutional violence, given that the responsibility to ensure healthcare services that respect women's rights lies with the state.

Nevertheless, it is essential to firmly maintain the gender-based perspective, which clearly reveals the discriminatory nature of these abuses. From the standpoint of anti-discrimination constitutional law, it can be asserted that forms of paternalism, denigration, and violation of women's dignity and medical self-determination unequivocally constitute discrimination against women - a form of discrimination that is inherently gender-specific. The paradigm of

of the doctor-patient relationship, reflecting the degeneration of the old medical paternalism. The birthing woman is portrayed as a patient incapable of self-determination, emotionally unreliable, and undeserving of information or involvement in decision-making regarding childbirth. As a result, childbirth is no longer seen as a natural process but rather as a "pathology" requiring surveillance, hospitalization, and control. M. Di Lello Finuoli, *Profili penali della c.d. violenza ostetrica*, cit., pp. 6 ss., argued that framing obstetric violence within the context of gender-based violence could obscure certain specific aspects of the phenomenon that are crucial for its criminological definition.

38. S. Levesque, A. Ferron-Parayre, *To Use or Not to Use the Term "Obstetric Violence": Commentary on the Article by Swartz and Lappeman*, in *Violence Against Women*, Vol. 27, Issue 8, 2021.

gender-based discrimination often intrinsically includes the element of intersectionality. Consider, for example, foreign women, migrants, or women with disabilities. These are categories of women who face gender-based discrimination in the medical field, first as women and second as members of additional minorities historically subjected to dual discrimination.

From a constitutional perspective, obstetric violence represents a violation not only of women's rights to health and dignity but also of the principle of non-discrimination, imposing an obligation on states to prevent, punish, and eradicate these practices. In this sense, the Latin American paradigm offers a normative and cultural framework that could inspire other legal systems to recognize and address this form of violence as a structural violation of women's human rights.

Obgyn Violence in the Southern Cone. Argentine and Chilean Experiences

Camila Díaz Pacheco

Summury: 1. About obgyn healthcare – 2. What is obgyn violence? – 3. The Argentine experience. The Law of Humanized Childbirth and the Law for the Integral Protection of Women – 4. The Chilean Experience. The Integral Law Against Violence Against Women – 5. Conclusions.

1. About obgyn healthcare

Since the beginning of civilization, female reproductive healthcare has been an important aspect of daily life. Evidence found in ancient Egypt described the treatments that women typically received during pregnancy[1]. In Rome, Soranus of Ephesus wrote the four-volume treatise on gynecology, which served as a guide for fifteen centuries[2].

Furthermore, during the Renaissance, the rediscovery of these classical documents led to the development of medicine, where various fields, such as midwifery, began to professionalize. For example, Eucharius Röslin, a German physician, authored a book about childbirth called *The Rose Garden* in 1513, which became the principal medical text for birth attendants[3].

1. Kahun Gynaecological papyrus, the oldest medical record dated to 1825 B.C.

2. M. Sedano, C. Sedano, R. Sedano, *Reseña histórica e hitos de la obstetricia*, in *Rev. Med. Clin. Condes* - 2014; 25(6) 866-873.

3. *Ibidem*.

During the Enlightenment, the use of medical instruments and new techniques became more widespread. It was in this period that ether was introduced in gynecological and obstetric procedures, facilitating the institutionalization of obstetrics and gynecology as two distinct medical specializations. From that time onward, the introduction of new discoveries and medical advancements has continued.

While it is true that professionalization and institutionalization of obstetrics and gynecology resulted in a reduction of maternal and newborns mortality rates, it also implied the standardization of the natural processes of pregnancy, labor, childbirth, and postpartum care. As a consequence, women began to be treated as pathologized patients who needed medication. This phenomenon has been studied, and as Al-Gailani and Davis noted, "since the 1970's medicalization has served as the dominant framework for the analysis of historical change in pregnancy and childbirth across the social sciences". In this context, many sociologists argue that the development of medicine is linked to the creation of a privileged and autonomous profession, with the aim of extending medical control into everyday life[4].

This shift resulted in the transformation of reproductive healthcare from a more personal and ritualistic process to a more impersonal one, where standardization meant the application of the same techniques and procedures to different bodies and circumstances, without consideration for the individual needs and characteristics of each woman.

The medical advancements in women's reproductive healthcare brought many positive developments, but at the same time, created the perfect scenario for instrumentalizing women's bodies as means to deliver new life.

It was in this context, after decades of standardizing procedures and medicalization – which led women to experience mistreatment as something they had to endure simply because they were bringing a new life into the world – that a new concept was coined in Latin America.

As discussed in previous chapters, during the 1990s, social and civil movements spoke louder about this issue, especially in response to rising population and maternal mortality rates across the region,

4. *Ibidem*.

many of which could have been avoided with proper care for mothers. Society became aware of the abuses women faced in maternity wards at the hands of healthcare personnel, including verbal, physical, and even sexual abuse at their most vulnerable moments. In response, to encompass all types of mistreatment under a single term, the community developed the concept of "obstetric violence," with Venezuela being the first State to legally recognize it.

Before continue with the conceptualization, it is important to note that obstetric violence and obgyn violence are not exactly the same. The former was a concept created by social movements in South America to describe the mistreatments within obstetrics, which is "the discipline that deals with pregnancy, childbirth, and the post-partum period"[5]. Obgyn violence, on the other hand, refers to the obstetrics violence, plus the abuses experienced during any other gynecological consultation, examination or emergency. As Cárdenas and Salineros explained, "gynaecological violence includes the practices exercise by healthcare personnel, in the context of gynaecological care and that naturalizes a subordination relationship between the provider and the patients. Also comprehend, psychological or physical violent actions infringed on the women's bodies, including any kind of sexual abuse and assault"[6]. This distinction is essential, because as my colleague explained in the previous chapter, Venezuela's initial definition only outlined what obstetric violence entailed, considering it as violence inflicted only to pregnant women, from the beginning of pregnancy through the post-partum stage.

2. What is obgyn violence?

The doctrine has characterized this type of violence as "sexist attitudes and remarks; verbal, physical, and sexual abuse; manipulation;

5. F. Chervenak, R. MacLeod-Srdjan, and others, *Obstetric violence is a misnomer*, in *American Journal of Obstetrics & Gynecology*, 2023, 1.

6. M. Cárdenas, S. Salinero, *Impacto y consecuencias de la violencia ginecológica en la vida de las mujeres*, in *Rev. Obstet Ginecol Venez.*, 2023; 83(1): 54-66. DOI: 10.51288/00830109.

and unconsented or unnecessary medical procedures"[7]. It materializes in deep structural violence, often linked to concepts of hierarchy, control, power, and status – where "often, care for pregnant people is understood to be secondary to the safety of the foetus during childbirth"[8]. Moreover, healthcare staff usually appear "to know not only more about the condition of the child but also about what is best for the child. Simultaneously, the mother is constituted as a complicating, instead of enabling, factor in the process of childbirth, whose main role is to somehow get through the painful event in a docile manner"[9].

In 2019, the UN Special Rapporteur of the Human Rights Council on Violence Against Women elaborated a report addressing the abuse and mistreatment of women in reproductive health services, with a focus on childbirth and obstetric violence. The Rapporteur highlighted that violence experienced by women in healthcare facilities during reproductive consultations is a common issue, yet there is a lack of global consensus on how this type of gender-based violence (GBV) is measured and defined. Furthermore, it recognized that this form of violence constitutes violence against women, applying the definitions given by the Declaration on the Elimination of Violence Against Women and the General Recommendation N°19 of the Committee on the Elimination of All Forms of Discrimination Against Women[10].

In 2022, the International Planned Parenthood Federation European Network released an article on gynecological and obstetric violence, not only referring to what had been previously explained but

7. R. van der Waal and K. Maya, *Obstetric Violence*, in P. Ali and M. Rogers (eds.), *Gender-Based Violence: A Comprehensive Guide*, Springer, 2023, 415.

8. *Ibidem*.

9. R. van der Waal and I. van Nistelrooij, *Reimagining relationality for reproductive care: Understanding obstetric violence as a separation*, in *Nursing Ethics*, 2022, Vol. 29(5), 1186-1197, 1189.

10. United Nations General Assembly, Resolution A/74/137, 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 and obstetric violence, 11 July paragraph 11.

also identifying a list of forms of obgyn violence, which includes: (i) forced contraception, sterilization or forced abortion; (ii) mistreatments during abortion; (iii) routine induction of labor; and (iv) routine cesarean sections. Two of these forms will be used as parameters and examples of obgyn violence in the Southern Cone.

From a legal perspective, obstetric or obgyn violence has been defined in only three national laws, all in South America. The first was Venezuela's Organic Law Nº 38.668 on Women's Right to a Life Free of Violence from 2007. In article 19(13), it describes this form of violence as the appropriation of women's bodies and reproductive processes by healthcare personnel, manifested in dehumanizing treatment, excessive medicalization, and the pathologizing of natural processes. This results in a loss of autonomy and the ability to make free decisions regarding one's body and sexuality, thereby negatively impacting women's quality of life.

Later, in 2014, the Organic Law Regarding Women's Rights to a Life Free of Violence was amended to include a legal definition of gynecological violence, expanding the scope of the protection to cover the entire spectrum of GBV in women's reproductive healthcare.

The conceptualization provided by the Venezuelan law served as an example and inspiration not only for other South American legal frameworks but for the regional and international community. This new terminology has been adopted and referenced by the Committee of the Convention for the Elimination of All Forms of Discrimination Against Women[11], the Inter-American System of Human Rights[12], and the Council of Europe[13], among others.

In 2009, Argentina passed the Law for the Integral Protection of Women, which, in article 6(e), defined obstetric violence as violence inflicted by healthcare personnel on women's bodies and reproductive

11. CEDAW Committee, CEDAW/C/75/D/138/2018, Decision adopted by the Committee under article 4 (2) (c) of the Optional Protocol, concerning communication No. 138/2018.

12. Inter-American Commission on Human Rights. Violence and discrimination against women and girls: Best practices and challenges in Latin America and the Caribbean. OAS/Ser.L/V/II. Doc. 233, November 14, 2019, para. 181.

13. Council of Europe, Resolution Nº 2306, 3 October 2019.

processes, manifesting in dehumanizing treatment, excessive medicalization, and the pathologizing of natural processes[14].

In 2024, Chile enacted the Integral Law Against Violence Against Women, defining obgyn violence in article 6(9) as any mistreatment or psychological, physical or sexual aggression, unjustified denial or abuse committed during a sexual or reproductive health consultation, particularly, during pregnancy, labor, childbirth, postpartum, abortion, or any other gynecological emergency.

As previously discussed, the legal recognition of this type of violence by national laws has occurred in only three South American States, but this does not mean that other regulations do not exist. For instance, in Mexico "24 federative units have incorporated in their statal laws regarding the access to a life free of violence an explicit definition for obstetric violence, and 7 of them have typified it as a crime: Aguascalientes, Chiapas, Guerrero, Estado de México, Veracruz, Yucatán, and Quintana Roo"[15].

In Europe, this form of violence is recognized in three Spanish autonomous communities: Catalonia, the Basque Country, and Valencia. The most progressive regulation is from Catalonia, which enacted the Law Nº 17/2020 and in article 4, it lists the various forms of gender-based violence, explicitly defining obgyn violence as "Obstetric violence and violation of sexual and reproductive rights consists of preventing or hindering access to truthful information, necessary for autonomous and informed decision-making. It can affect different areas of physical and mental health, including sexual and reproductive health and may prevent or make it difficult for women making decisions about their sexual practices and preferences and about their reproduction and the conditions in which it is carried out, in accordance with the assumptions included

14. Ley Nº26.485, artículo 6(e): "Violencia obstétrica: aquella que ejerce el personal de salud sobre el cuerpo y los procesos reproductivos de las mujeres, expresada en un trato deshumanizado, un abuso de medicalización y patologización de los procesos naturales, de conformidad con la Ley 25.929".

15. M. Cobo, A. Sáenz, P. Flores, *Obstetric Violence and Mexican Official Norms: An Opportunity to Improve Implementation Based on Reported Violations by Healthcare Personnel in Four General Hospitals in Mexico City*, in *Revista Jurídica Ibero*, Num.14, 2023, 19.

in specific legislation. It includes forced sterilisation, forced pregnancy, the impediment of abortion in legally established cases and difficulty in [obtaining] contraceptive methods, methods of prevention of sexually transmitted infections and HIV and assisted reproduction methods, as well as gynaecological and obstetric practices that do not respect the decisions, body, health and emotional processes of the woman"[16] .

The aim of this chapter is to examine how the topic of obstetric and obgyn violence has been addressed in the southern part of the world by reviewing the experiences of Argentina and Chile, the second and third State to legally defined obgyn violence as a a distinct and autonomous type of gender-based violence.

3. The Argentine experience. The Law of Humanized Childbirth and the Law for the Integral Protection of Women

In Argentina, as was the trend in the region, pregnant women suffered of mistreatment and abuse during their pregnancy care, labor, childbirth, and most notably, after undergoing an abortion. Between 1990 and 2008, an average of 40 women died per 100.000 newborns annually, with 26,7% of these cases resulting from complications after abortion (whether voluntary or medically induced). This rate is very high compared with the neighboring countries; in Chile, for the same period, 19,8 women died per 100.000 newborns, while in Uruguay, the rate was 15,0 women per 100.000 newborns[17].

I will use this statistic as a reference point just because, according to the World Health Organization, the majority of maternal deaths could have been avoided[18]. These deaths are often caused by "severe bleeding,

16. P. Quattrocchi, *Obstetric Violence in the European Union: Situational Analysis and Policy Recommendations*, in European Union Publications, 2024, 28 (*https://op.europa.eu/en/publication-detail/-/publication/74238fad-0b63-11ef-a251-01aa75ed71a1/language-en*).

17. M. Romero, E. Chapman, S. Ramos, and E. Abalos, *La situación de la mortalidad materna en la Argentina*, in *Observatorio de la Salud Sexual y Reproductiva*, No. 1, April 2010, 2.

18. World Health Organization, *Maternal Mortality,* April 2024 (*https://www.who.*

high blood pressure, pregnancy-related infections, complications from unsafe abortions, and underlying conditions that can be aggravated by pregnancy (such as HIV/AIDS and malaria) […] These are all largely preventable and treatable with access to high-quality and respectful healthcare"[19]. In other words, maternal mortality is frequently related to the mistreatment women receive during pregnancy, the lack of monitoring and diligence regarding preexisting health conditions, and the absence of postpartum care. These issues will be briefly discussed in the following paragraphs in relation to an important judicial decision by the Inter-American Court of Human Rights against the State of Argentina.

In response to this situation, Law Nº 25.929 for Humanized Childbirth was passed in 2004. As Herrera explained, the statute "recognizes the rights of women in health facilities during the provision of various maternal health services, characterizes over-medicalization as procedures that do not translate into better maternal health, or fail to prevent maternal mortality and morbidity"[20]. In consequence, and "in response to such over-medicalization, the Humanized Labor statute establishes health personnel's obligation not to prescribe medication and to avoid invasive practices unless such treatment is necessary for protection of the health of the mother or fetus"[21].

The law for Humanized Childbirth was the first legal body addressing the situation of Argentine women under the healthcare personnel's control during childbirth. As the author noted, it recognized a series of rights for the patient, the newborn, and the family, such as the right to be informed, to be treated with respect, and the right to natural

int/news-room/fact-sheets/detail/maternal-mortality#:~:text=Overview,most%20could%20have%20been%20prevented).

19. World Health Organization, *A woman dies every two minutes due to pregnancy or childbirth: UN agencies*, February 2023 (*https://www.who.int/news/item/23-02-2023-a-woman-dies-every-two-minutes-due-to-pregnancy-or childbirth--un-agencies*).

20. C. Herrera, *Obstetric Violence: A New Framework for Identifying Challenges to Maternal Healthcare in Argentina*, in *Reproductive Health Matters*, Vol. 24, No. 47, 2016, 67.

21. *Ibidem*.

childbirth, respecting each woman's biological and psychological timing. Nevertheless, the statute did not establish specific sanctions for violations. Article 6 merely states that any infringement will be considered a serious fault subject to administrative sanctions, without excluding the potential for civil and/or criminal liability[22].

The enactment of this law was a significant step forward in the development and protection of women's human rights. However, it was limited to abuses committed during childbirth, excluding obstetric violence experienced during other stages of maternal care. Moreover, the law broadly listed the rights recognized, without the necessary administrative decree to make it enforceable. It wasn't until 2015, eleven years after its publication and entry into force, that the Ministry of Health enacted Executive Decree Nº 2035/2015, finally issuing the order to implement the necessary complementary measures for enforcing Law Nº 25.929. Annex I of the Decree specified the duties and obligations of healthcare personnel in public and private healthcare institutions.

However, as mentioned earlier, the Law for Humanized Childbirth did not address obgyn violence as a broader phenomenon; it only referred to mistreatment received during childbirth. Consequently, Argentina did not have a legal recognition or definition of obstetric or obgyn violence until 2009, when the Congress approved the Law Nº 26.485 for the Integral Protection of Women, designed to fulfill Argentina's international obligations concerning the elimination of all forms of discrimination and violence against women.

At first glance, Law Nº 26.485 seemed to only address obstetric violence, limiting its scope to care during pregnancy, labor, childbirth, and postpartum. Yet, upon closer examination, the language used by the legislator provides a broader definition than the one elaborated by the Venezuelan Parliament in 2007. In fact, article 6(e) refers to the

22. Ley Nº 25.292 sobre el Parto Humanizado, artículo 6º: "El incumplimiento de las obligaciones emergentes de la presente ley, por parte de las obras sociales y entidades de medicina prepaga, como así también el incumplimiento por parte de los profesionales de la salud y sus colaboradores y de las instituciones en que éstos presten servicios, será considerado falta grave a los fines sancionatorios, sin perjuicio de la responsabilidad civil o penal que pudiere corresponder".

violence perpetuated by healthcare personnel over women's bodies and reproductive processes, manifested in dehumanized treatments, over-medicalization and pathologizing the process itself. Thus, even though the law uses the term "obstetric violence," it can encompass mistreatment suffered by women throughout their entire reproductive lifecycle.

Unlike the previous statute, the Executive Decree N° 1011/2010 for the Law N°26.485 was published one year after its enactment, and its provisions hold great significance. Through the Decree, the Presidency clarified many terms and concepts defined in the law. In the case of article 6(e), "dehumanizing treatment" was defined as any cruel, dishonorable, disqualifying, humiliating, or threatening treatment, and "healthcare personnel" was defined as anyone working in healthcare services, whether medical professionals (doctors, nurses, social workers, psychologists, obstetricians) or those in charge of hospital services or administrative employees.

It is worth highlighting the clarification of the term "reproductive processes," which included abortion care, even though at the time, voluntary termination of pregnancy was illegal. For the purpose of eliminating all forms of violence against women, mistreatment and abuse related to abortion were considered GBV. This is important because, as Herrera pointed out, many women reported abuse and discrimination during abortion procedures, "for example, through the practice of curettage without pharmacological pain relief, or verbal insults, judgmental, or derogatory remarks by emergency room staff"[23].

Finally, in in 2015, Law N°27.210 came into force, establishing the Body of Lawyers of Victims of Violence, an administrative body with the mission of guaranteeing access to justice for victims of GBV, in line with the provisions of the Law N° 6.485 for the Integral Protection of Women. The aim is to provide free legal representation to the victims of GBV across the country, in addition to developing mechanisms of protection and coordination with other public services and agencies,

23. C. Herrera, *Obstetric Violence: A New Framework for Identifying Challenges to Maternal Healthcare in Argentina*, in *Reproductive Health Matters*, Vol. 24, No. 47, 2016, 68.

and conducting training and educational activities, among other responsibilities.

Since 2015, women in Argentina have had a legal framework that promotes, protects, and guarantees their reproductive and fundamental rights – or at least, this is the theory. But have these legal and administrative regulations been sufficient to create a significant change in the reality of Argentine women? Unfortunately, Law N°26.485 did not initially include specific sanctions for violations. It was only in 2011 that the Ministry of Justice and Human Rights created CONSAVIG, a commission tasked with drafting an action plan and determining possible sanctions for cases of violence against women and violations of the Law for the Integral Protection of Women. In 2013, a special commission, CONSAVO, was also created to develop sanctions specifically for cases of obstetric violence[24].

The only reference to sanctions for violations of the law is found in article 32, and they apply only when a judicial procedure has been initiated through a direct complaint to a judge. These sanctions are quite "soft" and include: (i) a warning for the committed act; (ii) communication of the acts of violence to the aggressor's organization, institution, union, professional association or workplace; (iii) mandatory attendance of the aggressor to reflective, educational or therapeutic programs aimed at modifying violent behaviors. Consequently, when a woman is a victim of violence, the procedure consists of filing a complaint with one of the designated administrative bodies (e.g., CONSAVIG, the National Ombudsman, or a health agency) or directly with the appropriate judge, depending on the type of GBV.

In the case of an administrative complaint, the relevant body begins an investigation to gather all necessary information for an audit, enabling the authorities to develop recommendations and protocols for the specific health institution. On the other hand, if the complaint is made directly to a judge, Chapter II of the Law establishes an extraordinary but general process – a free and expedited procedure aimed at providing a faster resolution to the conflict and protection for

24. D. Galimberti, *Violencia obstétrica*, 2015, 7 (available *http://www.fasgo.org.ar/images/Violencia_obstetrica.pdf*.

the victim. However, the only applicable sanctions are those previously mentioned in article 32.

Sadly, data on the current situation of obstetric violence in Argentina is scarce. The mechanisms outlined in the law are generally used for other forms of GBV, such as domestic violence or violence in the workplace. Regarding obstetric violence, the principal body addressing the issue is the Observatory on Gender-Based Violence and Inequalities, which in 2022 published a report on complaints received through the public helpline 144 during 2021. Of these, 52 were related to obstetric violence. According to the statistics, 75% of the complaints concerned dehumanizing treatment, 52% related to disrespect for the woman's decisions, and 44% involved insufficient information provided to the patient about a procedure. The same report also highlighted other manifestations of obstetric violence: in 2019, of the 277,330 registered births, 37% were cesarean sections, 43.7% of patients were not allowed to have family support during childbirth, and 53.3% underwent episiotomies[25].

In my opinion, the lack of concrete sanctions for violations of women's rights, particularly, in the context of obgyn violence, is the primary reason this type of violence remains a significant issue in Argentina. This situation hinders the ability to escalate cases to the judicial system and demand accountability. In fact, only a few cases have been resolved by national courts, often in situations where mistreatment or abuse could be framed as civil liability or specific criminal offenses, such as severe injury due to medical malpractice. In 2022, the Public Prosecutor's Office published a judicial newsletter revealing that only six cases across the country (from 2017 to 2021) involved a court developing a specific concept of obstetric violence and addressing its scope[26].

As Díaz and Fernández explained "the normative initiatives and public policies adopted to eradicate obstetric violence and ensure

25. Ivi, 14.

26. Ministerio Público, Violence Obstétrica, Boletín Judicial, abril 2022 (available *chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.pensamientopenal.com.ar/system/files/2022.04.%20Violencia%20obst%C3%A9trica.pdf*).

a humanized childbirth haven't managed to crack and shake an organizational culture that violates women's, children's and families' rights"[27].

Finally, I will briefly discuss a significant judgment delivered on November 16, 2022, by the Inter-American Court of Human Rights against Argentina, where the Court declared the international responsibility of the Argentine State for the death of a 38-year-old pregnant woman after induced labor.

Cristina Brítez Arce, a Paraguayan woman residing in Argentina, began receiving pregnancy care in 1992 at Sardá Public Hospital, where she informed the medical staff about her high blood pressure, which was duly noted in her medical history. On June 1, 1992, at around 9:00 a.m., Cristina visited the hospital complaining of back pain, fever, and fluid leakage from her genitals. An ultrasound was performed, and she was informed that her fetus had died and that she would need an emergency induced labor, with no further explanations or alternative treatment options provided.

The procedure began at 1:45 p.m. and lasted nearly three hours. Cristina was then transferred to the maternity ward to recover, but due to a lack of infrastructure, she was placed in a chair despite being fully dilated. Tragically, she died at 6:00 p.m. from a "non-traumatic cardiopulmonary arrest".

To this day, three decades later, the exact cause of her death remains unknown, and none of the medical professionals involved have been held accountable for their negligence. The autopsy was conducted several days after her death, and the initial report was altered by the involved physicians, leading to its annulment during one of the civil proceedings.

The victim's family eventually brought the case to the Inter-American Commission on Human Rights, which found sufficient grounds to conclude that the facts demonstrated a violation of human rights by the Argentine State and its agents. The case was referred to the Inter-

27. L. Díaz, Y. Fernández, *Situación Legislativa de la Violencia Obstétrica en América Latina: El caso de Venezuela, Argentina, México y Chile*, in *Revista de Derecho de la Pontificia Universidad Católica de Valparaíso*, 51, 134.

American Court of Human Rights, which, in 2022, ruled on the case. The Court delivered an innovative judgment, referring to the definition of obstetric violence established by the Commission in 2019: "The Court has specifically ruled on violence during pregnancy, childbirth, and afterwards in accessing health services and has held that it is a violation of human rights and a gender-based form of violence called obstetric violence, which 'encompasses all situations of disrespectful, abusive, neglectful treatment or denial thereof that take place during the pregnancy, childbirth, or post-partum period, in private or public health facilities"[28].

For the first time within the Inter-American Human Rights System, the Court recognized a specific definition of obstetric violence, acknowledging it as a form of GBV that holds the State accountable when fundamental human rights – such as the right to health, personal integrity, and life – are violated.

Moreover, the Court revised its position on the justiciability of economic, social, and cultural rights, including the right to health. It interpreted this right under article 26 of the American Convention on Human Rights, derived from articles 34(i), 34(l), and 45(h) of the Charter of the Organization of American States, placing it on equal footing with civil and political rights[29].

With this judgment, the Inter-American Court condemned Argentina for negligence during pregnancy care – considering the patient's high blood pressure medical history – for violating Cristina's right to be informed (since the physicians only told her that she needed induced labor without providing explanations or alternatives), and for the mistreatment and abuse she suffered after the procedure, as she was left alone in a chair despite potentially suffering from preeclampsia. According to the Court, the combination of these circumstances led to Cristina Brítez's death, with her and her children's fundamental rights violated by the State of Argentina.

28. Inter-American Court of Human Rights, case Serie C Nº 474, Britez Arce et.al. v. Argentina, November 16, 2022, § 75.

29. *Ibidem*, § 61.

4. The Chilean Experience. The Integral Law Against Violence Against Women

Chile, like other countries in the region, is not free from obgyn violence. For instance, in 2017, the Observatory of Obstetric Violence conducted the First National Survey on Childbirth, an online survey that documented the experiences of women who gave birth between 1970 and 2017. Among the 8,696 births surveyed, the word "torture" was used to describe the birthing experience in 40 cases. In public hospitals, 69.9% of women experienced verbal abuse or psychological mistreatment between 1970 and 2008, which decreased to 43.4% between 2014 and 2017. Additionally, 31% of women reported physical abuse between 1970 and 2008, decreasing to 17.5% between 2014 and 2017[30].

For the purposes of this section, and following the parameter of maternal mortality used for Argentina, the point of comparison in Chile is the rate of unnecessary cesarean sections. A cesarean section "is a fetal delivery through an open abdominal incision (laparotomy) and an incision in the uterus (hysterotomy)"[31].

In 2018, the WHO issued the "recommendations for non-clinical interventions to reduce unnecessary cesarean sections," acknowledging that this procedure had been increasing over recent decades without medical or scientific evidence proving any benefits for the mother or newborn. In fact, as stated in the report, "there is evidence that, beyond a certain threshold, increasing caesarean section rates may be associated with increased maternal and perinatal morbidity"[32].

The WHO reported that for nearly 30 years, the international community has agreed that the ideal c-section rate should be between 10% and 15%. However, as of the 2018 recommendations, data collected from 150 countries showed that the global c-section rate was

30. Ivi, 36.

31. H. Mahdy, S. Sung, *Cesarean Section*, in *StatPearls*, National Library of Medicine, 2023 (available *https://www.ncbi.nlm.nih.gov/books/NBK546707/*).

32. World Health Organization, "Recommendations non-clinical interventions to reduce unnecessary caesarean sections", 2018, 8.

18.6%, ranging from 1.4% to 56.4%. Latin America and the Caribbean led the ranking, with an average rate of 40.5%[33].

Cesarean sections are recognized as a form of obgyn violence because childbirth is no longer seen as a natural process, but rather as a medical procedure requiring intervention. Women are often viewed as mere vessels for delivering new life, necessitating surgical or medical intervention. Guzman et al. (2015) explained this by saying "It has been stated that the difference in rates between developed countries is based on the different approaches towards labor and delivery. Countries with a less "medical" or less "interventional" approach have lower rates, compared with countries that have more of a "medical" or "interventional" approach"[34].

According to experts, in 2015, Chile had "a cesarean rate of 40% for the population attending hospitals of the public sector, and 70% cesarean section rates for women attending private clinics; in addition, almost all deliveries in private clinics are done by physicians. In these clinics, a "medical" approach toward labor and delivery prevails"[35].

In 2021, the Observatory of Obstetric Violence requested data from the Ministry of Health regarding cesarean sections performed in Chile that year. It found that 59% of all births were by cesarean section, with 49% in the public system and 73% in private institutions[36]. Several factors contribute to the overuse of c-sections in Chile, some of which are unusual and reinforce the perception of women as mere instruments for delivery, rather than as human beings with rights. For instance, "the misconception that cesarean birth is better for babies; or better remuneration for cesarean birth compared to vaginal delivery; or the fear of litigation"[37]. The observatory also found that in many cases,

33. Ivi, 12.

34. E. Guzman, J. Ludmir, M. DeFrancesco, *High Cesarean Section Rates in Latin-America, a Reflection of a Different Approach to Labor?*, in *Open Journal of Obstetrics and Gynecology*, 2015, 5, 433-435, 434.

35. *Ibidem*.

36. M. Sadler, G. Leiva, *Más cesáreas que nunca en Chile* (available *https://www.ciperchile.cl/2023/01/11/mas-cesareas-que-nunca-en-chile/*).

37. E. Guzman, J. Ludmir, M. De Francesco, *High Cesarean Section Rates in Latin-America, a Reflection of a Different Approach to Labor?*, 434.

women are encouraged from the beginning of pregnancy to choose c-sections as a "safer" procedure, allowing hospitals and physicians to manage childbirths with economic interests in mind[38],

Performing cesarean sections without medical necessity is a form of obgyn violence because it not only affects the woman's body and health but is often associated with a lack of information, inadequate informed consent, over-medicalization of labor, and the instrumentalization of women's bodies. According to the medical community, cesarean sections are beneficial only in emergency situations or when specific medical conditions are present, such as, the existence of previous perineal trauma, prior pelvic or anal/rectal reconstructive surgery, or pathology requiring concurrent intraabdominal surgery. In cases where no such complications exist, the risks of maternal mortality increase due to a higher likelihood of hemorrhage or postpartum infection[39].

So, what was the legal response to this context? The first official document addressing reproductive rights was the "Handbook on Personalized Care in the Reproductive Process", published by the Ministry of Health in 2008, during President Michelle Bachelet's first term. The handbook aimed to provide recommendations to healthcare institutions to improve services during pregnancy, labor, childbirth, and postpartum. It introduced concepts such as gender-based violence, gender perspectives, and sexual and reproductive rights. Sadler et al. observed that this handbook positively impacted the experiences of birthing women, as shown in the results of the First National Survey mentioned earlier. However, women continued to experience high rates of obgyn violence, particularly in relation to cesarean sections[40].

In 2012, Law No. 20.584 came into force, regulating the rights and duties of individuals in relation to healthcare services. Although this law broadly addressed patient rights and duties, some of its provisions are relevant to cases of women experiencing obgyn violence, like the

38. M. Sadler, G. Leiva, *Más cesáreas que nunca en Chile*, cit.

39. S. Sung, H. Mahdy, *Cesarean Section*, StartPearls Publishing, 2024 (available *https://www.ncbi.nlm.nih.gov/books/NBK546707/*).

40. M. Sadler *et al.*, *OVO Chile 2018, Resultados Primera Encuesta Sobre Nacimientos en Chile*, in *ResearchGate*, 2018.

recognition of the right to a dignified treatment (art. 4); the right to be informed about the own health status, diagnose and alternative treatments (art. 10); and informed consent for procedures (art. 14). However, the law's application depended heavily on the interpretation of healthcare personnel and, subsequently, judges, who often did not consider gender perspectives in cases brought before the courts.

We had to wait until 2017 when, through a Presidential initiative during the second term of President Michelle Bachelet, a project for an Integral Law Against Violence Against Women was submitted to the Chamber of Deputies. The significance of this project lies not only in the legal identification and recognition of GBV but also in the adoption of a series of legal definitions that would shape our national framework, including the definition of obstetric-gynecological violence.

The project responded to Chile's international obligations under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (Belem do Pará). As I will explain later, the text expressly references these conventions to guide its interpretation.

Fortunately, after six years of discussion and revision, the project was approved and published in the Official Gazette on June 14, 2024, officially becoming Law Nº 21.675, which Establishes Measures to Prevent, Punish, and Eradicate Gender-Based Violence Against Women. At the time of writing this chapter, only a few months have passed since the law's publication and enforcement, so I do not have any information or data on its impact. Due to this, I will focus solely on analyzing the content of Law Nº 21.675 and comparing the innovations made by the Chilean Congress with the Argentine framework.

Similar to the Law Nº 26.485 (Argentina), article 1º of the Chilean text outlines the law's objectives. Following the mandates of the CEDAW and Belem do Pará conventions, it establishes the prevention, punishment, and eradication of GBV as its primary goal.

Article 2 recognizes girls, adolescents, and women as subjects of this law, providing specific definitions for each term. This ensures that the concept of GBV and violence against women applies not only to adult women but also to girls and adolescents. This is an innovative

aspect because, in Argentina, Law Nº 26.485 does not include a similar provision. However, it is possible to interpret that the law considers GBV cases involving girls and adolescents under article 3, which refers to the Convention on the Rights of the Child and Argentina›s Law for the Comprehensive Protection of the Rights of Girls, Boys, and Adolescents.

Article 4 of Law Nº 21.675 (Chile) mandates that the law be interpreted in a systematic and harmonized manner with international human rights treaties, in accordance with the Chilean Constitution, the Convention on the Elimination of All Forms of Discrimination Against Women, the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women, and other international treaties ratified by Chile. This provision opens up broader possibilities for protecting and promoting human rights, granting victims direct access to mechanisms recognized by both national and international law and allowing the direct application of Chile's human rights obligations.

In article 5, after defining GBV, the law states that violence against children and adolescents aimed at harming their mothers or caregivers should be considered a form of GBV. This explicitly recognizes vicarious violence – violence directed at minors to harm the woman responsible for them. This is a significant addition, as vicarious violence has not been unanimously recognized as a form of GBV in many national frameworks or international treaties, making it challenging for judges to identify and hold perpetrators accountable for GBV against children.

Article 6 enumerates the forms of GBV recognized by the Chilean framework, including: (i) physical violence; (ii) psychological violence; (iii) sexual violence; (iv) economic violence; (v) symbolic violence; (vi) institutional violence; (vii) political violence; (viii) violence in the workplace; (ix) obgyn violence. Unlike earlier efforts in Venezuela and Argentina, which focused only on obstetric violence, Chile's law takes a broader approach from the outset by defining gynecological violence as well. This allows for a wide interpretation of what can be considered obgyn violence. It includes all mistreatment, aggression, and abuse – psychological, physical, or sexual – during any sexual or reproductive health consultation, especially during pregnancy, labor,

childbirth, postpartum, and abortion, or any other gynecological emergency. Thus, Chile recognizes obgyn violence as encompassing the entire reproductive life cycle, from the first medical consultations to pregnancy and abortion care.

Regarding abortion, it is important to note that voluntary pregnancy termination is illegal in Chile, with exceptions only in cases of rape, risk to the woman's life, or when the fetus has a congenital or genetic pathology incompatible with life outside the womb. However, Law Nº 21.675 does not differentiate between these cases, meaning that any mistreatment or abuse during an abortion would be considered obgyn violence under this law.

The text also establishes duties and obligations for public institutions and services, including the development of public policies, educational plans, and internal measures to ensure compliance with the law. An Inter-Institutional Commission on Gender-Based Violence was created, composed of representatives from the Ministry of Women and Gender Equality, the Ministries of Health, Education, Social Development, and Justice and Human Rights, and the police. This commission is tasked with coordinating national efforts to prevent, punish, and eradicate GBV and to care for, protect, and provide reparations to victims.

Lastly, like Argentina's law, Law Nº 21.675 does not include a list of specific sanctions for general violations. Chapter III governs women's access to justice in cases of GBV, outlining the jurisdiction of criminal and family courts depending on whether the offense constitutes a criminal act or a family matter. However, the problem arises when obgyn violence does not fit into family law or criminal categories, limiting access to justice for victims. This leaves the regulation mostly theoretical, without offering a real solution. It is very likely that, if the public policies regarding education, capacitation and the implementation of an action plan by the governmental, judicial and administrative bodies is not complete, the results of the implementation of the law will not have significant effects regarding obgyn violence, as was the case in Argentina.

I hope the implementation of this new law will lead to a deeper commitment to addressing the daily violence women face, particularly in reproductive healthcare. I also hope that the recognition of obgyn

violence as a form of GBV will trigger further legal changes and the development of specific regulations, such as the inclusion of obgyn violence in the criminal code – following the example of some Mexican states – so that victims can receive real protection and justice.

What I mentioned above is very important, which is why I will refer to project Nº 12148-11, that "Establishes Rights in the Areas of Gestation, Labor, Childbirth, Postpartum, Abortion, Gynecological and Sexual Health, and Sanctions Gynecological-Obstetric Violence," that has been under discussion in Parliament since 2018.

Similar to the Humanized Childbirth Law in Argentina, this project aims to regulate, guarantee, and promote the rights of pregnant women, newborns, and partners during pregnancy, labor, childbirth, postpartum, and abortion care.

In article 3, the project defines obgyn violence as any mistreatment or physical, psychological, or sexual aggression, or any omission or unjustified denial that occurs during the medical care of pregnancy, labor, childbirth, postpartum, legal abortion, or any other sexual or gynecological consultation. Then, in article 4, it provides a non-exhaustive list of manifestations of obgyn violence, including abandonment, abuse, insults, threats against a woman attending an obstetric or gynecological consultation; forcing a woman to give birth in a position that restricts her movement or to be tied down without her consent; forced abortion or sterilization without her consent or without medical justification; and disrespect for her cultural traditions, among others.

In addition to this, the project also addresses the rights recognized for women regarding pregnancy, labor, childbirth, postpartum, and abortion, as well as the rights specifically granted to newborns and partners. Most importantly, it includes provisions on medical responsibility for obgyn violence and procedures for victims to file complaints.

In fact, the statute creates a new type of liability called "health responsibility", under which public and private healthcare providers will be held accountable for injuries caused to women during pregnancy, labor, childbirth, post-partum and abortion, or any other sexual or gynecological consultation. Furthermore, it proposes an amendment to

the Criminal Code to include the commission of crimes in the context of obgyn violence as an aggravating factor for criminal responsibility.

As a result, this potential legal framework is fully compatible with the existing Law Nº 21.675. It represents an important development in the regulation of obgyn violence, transforming the theoretical definition provided by the latter into actionable mechanisms of human rights protection. Women would have concrete tools to file claims and combat obgyn violence, as healthcare institutions and personnel would be held accountable for violence during gynecological and obstetric consultations, not only during pregnancy care but throughout the entire reproductive lifecycle.

5. Conclusions

Meanwhile violence against women and obgyn violence is a global issue, approaches to solutions vary in effectiveness. South America has been more progressive in addressing this matter, but current developments are still insufficient.

As noted, the Southern Cone, comprising Argentina and Chile, has been tackling the issue for almost two decades. Argentina, having the most progressive framework after Venezuela, began its efforts with the establishment of a list of rights recognized for women, newborns, and families during childbirth. This list outlines the duties and obligations that healthcare providers must uphold to ensure dignified and secure treatment for patients. In 2009, Argentina approved the Law for the Integral Protection of Women, which not only defined gender-based violence and violence against women but also enumerated the manifestations and types of GBV identifiable at the time, including the widely recognized obstetric violence. This law complemented the existing statutes of protection for women in general.

Subsequently, this legal framework was enhanced by the approval of a law that established a body of attorneys tasked with representing and defending victims of GBV in court to seek accountability. However, the lack of applicable sanctions for cases of obstetric violence has perpetuated a continuous cycle of infringements, leaving healthcare personnel without real accountability.

Nevertheless, we must remain hopeful, as the delivery and publication of the judgment by the Inter-American Court of Human Rights may lead to more changes and developments in the specific fields of obgyn care.

On the other hand, Chile took some time but eventually followed the example of its neighboring country. In 2024, Chile approved Integral Law Nº 21.675 Against Violence Against Women, which similarly defines the principal concepts of GBV and recognizes types of violence within the legal framework, including obgyn violence. For this conservative society, the establishment of a special law addressing violence against women is a significant step forward, even though the statute only provides a broad legal framework, delegating its specifications to an executive decree.

However, nothing has been said yet; Chile is awaiting the final discussion and approval of the project for Respectful Childbirth, which is dedicated exclusively to obgyn violence, the rights of women, and the responsibilities of perpetrators. If this legal initiative becomes law, the framework for addressing obstetric violence will change dramatically. It will not only be recognized theoretically as a form of GBV but will also include concrete mechanisms for victims to seek accountability through the implementation of a new type of liability called "health responsibility," along with revisions to its criminal code.

Regardless of what happens next, one thing is certain: the journey initiated 20 years ago by civil movements in the region has led to significant efforts from the international community, sparking interest in women's rights and integrity. The influence of South American conceptions and regulations in this area is undeniable.

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Part Two
The "Other" Side and the Voices of Medical Doctors

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Reproductive Violence, Changing the Paradigm. Towards Reproductive Health of Individuals

Irene Cetin, Francesca Gigli

Summary: 1. Introduction – 2. Birth plans – 3. Satisfaction surveys – 4. Conclusions.

1. Introduction

Improvements in maternal clinical practices during delivery, particularly in relation to the change from home to hospital deliveries, and the consequent use of protocols and monitoring instruments have indeed played a pivotal role in reducing maternal and perinatal mortality rates. This progress is a testament to the effectiveness of implementing stringent protocols and ensuring access to quality healthcare services for expectant mothers. Continuously refining and enhancing these protocols is essential for sustaining these positive outcomes. In this context, it is crucial to adopt a holistic approach to maternal health that addresses not only the medical aspects, but also the psychological support. By prioritizing maternal safety and well-being at every stage of pregnancy and childbirth, we can further reduce maternal mortality rates and ensure healthier outcomes for both mothers and their babies, but we have to pursue also maternal (and paternal) wellbeing.

Finding the balance between humanizing childbirth and ensuring maternal safety during emergencies is a delicate but necessary endeavor. While hospital deliveries have significantly reduced maternal and perinatal mortality, it is important to preserve the human aspect of childbirth. Humanizing birth involves respecting the autonomy,

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dignity, and preferences of the mother while providing the necessary medical care and support.

A critical topic to discuss is the concept of "obstetric violence." This term is used in some parts of the world to describe various forms of substandard and disrespectful care during labor. However, it suggests a serious form of aggression, carried out by obstetricians with the intent to cause harm. While intentional obstetric violence may occur in some instances, navigating the boundaries between culturally acceptable practices and respecting individual autonomy and rights can be complex, especially in the context of childbirth[1].

At the heart of this issue lies the principle of informed consent and patient-centered care.

The informed consent process becomes more complicated during pregnancy because of the presence of the fetus and the obstetrician–gynecologist's dual concern for maternal and fetal well-being. Nevertheless, the ethical obligation to obtain informed consent, using shared decision-making, does not change based on pregnancy or parenting status. According to the American College of Obstetricians and Gynecologists Practice Bulletin of 2009[2] "a patient who is pregnant is fully capable of making medical care decisions during pregnancy and during labor and delivery, even if those decisions are in disagreement with obstetrician – gynecologists or family members, involve withdrawal of life-sustaining treatment, or may adversely affect the health of the fetus".

Women should be empowered to make decisions about their own bodies and childbirth experiences based on their preferences, values, and medical needs. This means actively involving them in decision-making processes, providing comprehensive information about available options, and respecting their choices, even if they diverge from cultural norms or medical recommendations.

1. D. Morena, L. De Paola, M. Ottaviani, F. Spadazzi, M.V. Zamponi, G. Delogu, N. Di Fazio, *Obstetric Violence in Italy: From Theoretical Premises to Court Judgments*, in *Clin Ter.*, 2024 Jan-Feb, 175(1):57-67.

2. *Informed Consent and Shared Decision Making in Obstetrics and Gynecology: ACOG Committee Opinion*, Number 819, in *Obstet Gynecol.*, 2021 Feb. 1;137(2).

Instead of viewing pregnancy as a condition inevitably leading to childbirth, healthcare providers should approach it as a unique and individualized journey for each woman. This requires engaging in open and respectful conversations with the woman to understand her values, goals, and concerns regarding childbirth. These discussions should ideally begin during prenatal care appointments and continue throughout pregnancy, giving the woman ample time to explore her options, ask questions, and voice her preferences. Time of communication is indeed a fundamental aspect of medical care[3] and it is essential to dedicate adequate time to all patients, regardless of the complexity of their conditions or the constraints of the healthcare system.

Finding the right balance between informing, empowering expectant mothers, while reducing maternal stress during pregnancy and childbirth, can be challenging, especially given the multitude of potential scenarios that could arise. It is essential to tailor communication to each woman's needs, taking into account factors like her level of understanding, cultural background, and emotional state. Tension between autonomy, beneficence, and non-maleficence may cause conflict between a woman and her caregivers impeding communication, compromising care, and contributing to poor fetal and maternal outcomes in some cases[4].

Since labor and delivery can be unpredictable, informing pregnant women about potential complications is crucial for their understanding and preparedness. A patient-focused survey conducted in the Highlands of Scotland gathered information on pregnant women's knowledge and preferences regarding emergency interventions. The survey found that women were receptive to receiving more information about emergency obstetric interventions during the antenatal period. Women were less aware of the common obstetric emergency interventions like episiotomy and assisted vaginal delivery, though they were more aware of the risk of caesarean section. It is

3. Legge n. 219 del 22 dicembre 2017, "Disposizioni in materia di consenso informato e di disposizioni anticipate di trattamento".

4. T.E. Sturgeon, H. Ayaz, K. McCrorie, K. Stewart, *Informed consent in obstetrics - a survey of pregnant women to set a new standard for consent in emergency obstetric interventions*, in *J Obstet Gynaecol.*, 2021 May; 41(4):541-545.

concerning that while pregnant women may have relatively high levels of knowledge regarding the potential need for a cesarean section, there may be insufficient information provided about alternative delivery options, such as operative vaginal delivery. This lack of comprehensive information can contribute to dissatisfaction and feelings of distress among women who undergo operative deliveries without prior awareness or understanding.

Given that all modes of delivery carry risk, there is ongoing discussion about how obstetrical providers can ensure that patients are well-informed about their options[5]. In the newly introduced section of the Italian guidelines on pregnancy care, the focus on communication underscores its vital role in supporting women's health and well-being during pregnancy.

2. Birth plans

One strategy to inform women about safe, feasible, and evidence-based birth choices, while also helping them express and explore their preferences and wishes regarding childbirth, is the birth plan. A birth plan is a document that outlines a woman's preferences for pain management, labor positions, choice of a support person during labor, preferences for interventions such as cesarean sections or assisted delivery, and postpartum care preferences, among other things. It is a valuable tool to facilitate communication between women and their healthcare providers[6].

The provider's perspective on the matter may sometimes be at odds with those benefits. In one study, of a cohort of 77% physicians and 22% midwives between 2015-2016, most of the providers (66.5%) did not recommend birth plans, and nearly one third thought birth plans

5. K.S. Levy, M.K. Smith, M. Lacroix, M.H. Yudin, *Patient Satisfaction with Informed Consent for Cesarean and Operative Vaginal Delivery*, in *J Obstet Gynaecol Can.*, 2022 Jul; 44(7):785-790.

6. T. Ghahremani, K. Bailey, J. Whittington, A.M. Phillips, B.N. Spracher, S. Thomas, E.F. Magann, *Birth plans: definitions, content, effects, and best practices*, in *Am J Obstet Gynecol.*, 2023 May; 228(5S):S977-S982.

were predictive of adverse obstetrical outcomes[7]. However, having a birth plan does not imply a lack of trust in healthcare providers. Instead, it is a way for women to actively participate in their care and ensure that their preferences are known and respected throughout the childbirth process. The goal is to discuss birth plans and preferences with all pregnant people and to start discussion and documentation of birth plans early in gestation.

3. Satisfaction surveys

Another strategy to improve communication and address women's needs during childbirth is the use of satisfaction surveys. These surveys provide valuable feedback from women about their experiences, allowing healthcare providers to identify areas for improvement and tailor care accordingly. Satisfaction surveys can cover various aspects of the childbirth experience, including communication with healthcare providers, pain management, support during labor, decision-making processes, and overall satisfaction with care received. By analyzing survey responses, healthcare providers can gain insights into women's perspectives and preferences, helping them to better meet the needs of future patients. Additionally, satisfaction surveys can serve as a tool for accountability and quality improvement within healthcare facilities. Regularly collecting and analyzing survey data allows healthcare providers to track trends over time, implement targeted interventions to address areas of concern, and monitor the impact of quality improvement initiatives.

Few data have been published in Italy on women's experiences during childbirth. In 2019, a large national survey conducted by the main scientific societies (AOGOI, SIGO, and AGUI) collected opinions from women who gave birth in a high number of Italian birth centers[8]. This study is, to our knowledge, the largest survey conducted

7. Y. Afshar, J. Mei, J. Fahey, K.D. Gregory, *Birth Plans and Childbirth Education: What Are Provider Attitudes, Beliefs, and Practices?*, in *J Perinat Educ.*, 2019 Jan 1; 28(1):10-18.

8. G. Scambia, E. Viora, N. Colacurci, C. Longhi, *Patient-reported experience*

in a southern European country on women' hospital birth experience. It demonstrated that the majority of Italian women are generally satisfied with their childbirth experience, but that the communication of information and pain management should be improved, particularly in the case of emergency cesarean section or operative vaginal delivery.

Despite the increase in fathers attending births, their feelings and experiences have not been extensively studied. The scientific literature reveals that fathers have their own positive feelings regarding birth. A study highlights differences in mothers' and fathers' birth satisfaction and the factors predicting it, concluding that it is important to take into account the birth experience of each parent and to support parents accordingly by adapting care surrounding childbirth[9]. Another study state that partners may feel very vulnerable and stressed in this unfamiliar situation. They need emotional and informal support from staff, want to be actively involved, and play an important role for the birthing woman. To promote good attachment for parents, systematic exploration of the needs of partners is essential for a positive birth experience. Because of the diversity of family constellations, all partners should be included in further studies, especially same-sex partners[10].

Our Institute, the Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico of Milan, is now introducing a satisfaction survey to gather feedback from all women giving birth in our labor ward about their childbirth experiences. The survey investigates different aspects of obstetric care such as staff kindness and availability, empowerment, appropriate communication, emotional support, communication in case of operative vaginal delivery or episiotomy, feeling of disrespect, attention to emotional needs, pain control, sense of control over the situation, information about skin-to-skin contact, support during this

of delivery: A national survey in Italy, in *Eur J Obstet Gynecol Reprod Biol.*, 2020 Jan; 244:197-198.

9. M.N. Bélanger-Lévesque, M. Pasquier, N. Roy-Matton, S. Blouin, J.C. Pasquier, *Maternal and paternal satisfaction in the delivery room: a cross-sectional comparative study*, in *BMJ Open.*, 2014 Feb 24; 4(2):e004013.

10. N. Schmitt, S. Striebich, G. Meyer, A. Berg, G.M. Ayerle, *The partner's experiences of childbirth in countries with a highly developed clinical setting: a scoping review*, in *BMC Pregnancy Childbirth*, 2022 Oct 3; 22(1):742.

procedure, and general assessment of care received. Preliminary data highlight the need for better communication during the induction of labor phase and the need for better postpartum pain control.

4. Conclusions

In conclusion, ensuring the psychophysical well-being of women and unborn children, fostering positive interactions between pregnant women and medical staff and actively working to reduce the grounds for litigation should become priorities for all healthcare providers in order to improve women satisfaction with their childbirth experience.

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Obstetric and Gynaecological Violence as a Form of Gender-based Violence

Giussy Barbara, Laila Micci, Edgardo Somigliana

1. Introduction

Violence against women is a form of gender-based violence perpetrated against women on the basis of their gender or that has a disproportionately adverse impact on women. In accordance with the Istanbul Convention (Article 3) the term 'gender' shall be understood to refer to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men[1]. Violence against women refers to all forms of gender-based violence that result in or are likely to result in physical, sexual, psychological, or economic harm or suffering to women. This includes, but is not limited to, threats of such acts, coercion, or arbitrary deprivation of liberty, whether they occur in public or private life. This is precisely the definition set forth by the Declaration on the Elimination of Violence against Women in 1993[2].

1. The Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention), Council of Europe, Instanbul May 2011. Available at: *https://www.coe.int/en/web/conventions/full-list?module=treaty-detail&treatynum=210* (Accessed October 2024).

2. United Nation, Declaration on the Elimination of Violence against Women: resolution / adopted by the General Assembly, UN. General Assembly (48th

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Obstetric and gynaecological violence can be defined as any disrespectful or abusive behaviour towards women perpetrated by health professionals when providing sexual and reproductive health services. This involves a wide range of different procedures, including obstetric care during pregnancy, assistance with childbirth, breastfeeding counselling, gynaecological examinations, abortions, medically assisted procreation, and contraceptive prescription. It also includes non-medically necessary procedures that may be harmful, forced medical acts and/or medical acts performed without consent[3,4,5].

The term "obstetric and gynaecological violence" is a relatively recent concept. Furthermore, women who have been subjected to obstetric and gynaecological violence may also experience difficulties in recognising and labelling this form of abuse. However, in recent years, there has been a notable increase in awareness-raising initiatives by civil society organisations, contributing to a growing understanding of this specific type of violence. The majority of initiatives have concentrated on the issue of obstetric violence, with relatively limited information available on initiatives addressing gynaecological violence.

The question arises as to whether obstetric and gynaecological violence can be considered a specific form of gender-based violence, and thus sexist in nature, and whether reflects a patriarchal culture that continues to exert a dominant influence in society, including the medical field. The purpose of this chapter is therefore to provide an overview of how (and whether) the phenomenon of obstetric and

sess.: 1993-1994). Available at *https://digitallibrary.un.org/record/179739?v=pdf* (Accessed October 2024).

3. R. Jewkes, L. Penn-Kekana, *Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence against Women*, in *PLoS Med.*, 2015 Jun 30; 12(6):e1001849. DOI: 10.1371/journal.pmed.1001849. PMID: 26126175; PMCID: PMC4488340.

4. J.M. Martínez-Galiano, J. Rodríguez-Almagro, A. Rubio-Álvarez, I. Ortiz-Esquinas, A. Ballesta-Castillejos, A. Hernández-Martínez, *Obstetric Violence from a Midwife Perspective*, in *Int J Environ Res Public Health*, 2023 Mar 10; 20(6):4930. DOI: 10.3390/ijerph20064930. PMID: 36981838; PMCID: PMC10049399.

5. WHO, *The prevention and elimination of disrespect and abuse during facility-based childbirth*, September 2014. Available at: *https://iris.who.int/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf* (accessed October 2024).

gynaecological violence can be situated within the broader context of gender-based violence. It will provide a summary of the positions of various societies and political organisations that have addressed this issue, while also providing insights into aspects that remain unclear, controversial or subject to ongoing debate.

2. The Institutional context

Both the United Nations (UN) General Assembly and the European Parliament have acknowledged the existence of obstetric and gynaecological violence as a specific form of gender-based violence[6,7].

In particular, the UN General Assembly on violence and mistreatment against women in reproductive health services specified that the definition of violence against women, as delineated in Article 1 of the Declaration on the Elimination of Violence against Women, is applicable to Obstetric violence.

In Resolution No. 2306 of the Parliamentary Assembly of the Council of Europe on Obstetrical and Gynaecological Violence, adopted in 2019, obstetric violence is clearly defined as a form of gender-based violence. This form of violence has long been hidden and is still too often ignored. The document concludes by emphasising that instances of gynaecological and obstetric violence serve to illustrate the existence of significant gender inequalities, whereby the voices of women are not given sufficient consideration[8].

6. United Nations General Assembly, *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*, A/74/137; Distr.: General 11 July 2019. Available at: *https://digitallibrary.un.org/record/3823698?v=pdf* (accessed October 2024).

7. European Parliament, *Sexual and reproductive health and rights in the EU, in the frame of women's health*, P9_TA(2021)0314. 24 June 202. Available at: *https://www.europarl.europa.eu/doceo/document/A-9-2021-0169_EN.html* (accessed October 2024).

8. Council of Europe Parliamentary Assembly, *Resolution 2306: Obstetric and Gynaecological Violence*, 2019. Available at: *https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28236* (accessed October 2024).

In the 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 and obstetric violence," the United Nations General Assembly has identified a number of gender stereotypes as the root causes of obstetric and gynaecological violence[9]. These include, for example, discriminatory national laws or practices that require spousal or third-party consent for women's medical treatment, effectively denying their right to make decisions about their own health care. Such laws contribute to the abuse and violence that women may experience in the context of reproductive health services.

In addition, there are several examples of harmful gender stereotypes related to reproductive health that limit women's autonomy and agency. Such stereotypes include beliefs about women's decision-making power, natural role in society, and motherhood. The perpetuation of destructive gender stereotypes related to reproductive health, including the notion that women are innately less competent to make decisions, that their role in society is naturally subordinated to that of men, and that motherhood is their sole purpose, collectively affect women's autonomy and agency. Such stereotypes arise from deeply rooted religious, social, and cultural beliefs and ideas about sexuality, pregnancy, motherhood, perceptions of femininity, and in some cases (particularly in the context of obstetric care) may be further reinforced by the notion that childbirth is a naturally painful experience for women. Women are encouraged to express joy at the birth of a healthy infant, while their own physical and emotional well-being is frequently overlooked. The UN report also recognize that deficiencies and limitations in the health system can also be identified as the fundamental drivers of mistreatment and violence against women during childbirth. The inadequate working conditions

9. D. Simonovic, UN. Human Rights Council. Special Rapporteur on Violence against Women and Girls, its Causes and its Consequences; UN. Secretary-General. A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence: note / by the Secretary-General. 2019. Available *at https://digitallibrary.un.org/record/3823698?v=pdf* (accessed October 2024).

experienced by many health professionals, coupled with the historical over-representation of men in the health workforce, is in stark contrast with the obligation of states to ensure the accessibility, quality and availability of maternal health-care services, facilities and trained professionals, as well as to ensure gender equality among healthcare providers.

The "European Parliament Resolution on sexual and reproductive health and rights" adopted in 2021, identifies gynaecological and obstetrical violence as a form of sexual and reproductive health abuse, discrimination, and human rights violation motivated by gender hatred. The European Parliament calls upon the Member States to implement measures that guarantee access without discrimination to high-quality, accessible, evidence-based, and respectful maternity, pregnancy, and birth-related care. This should be done in accordance with the standards set forth by the World Health Organization. Laws, policies and practices that exclude certain groups from access to maternity, pregnancy and childbirth-related care should be reformed. This requires the elimination of discriminatory legal and policy restrictions based on sexual orientation or gender identity, nationality, racial or ethnic origin and migration status. Moreover, the Member States are urged to take all feasible steps to ensure that women's rights and dignity are respected in childbirth. Furthermore, they are called upon to unequivocally denounce and eradicate all forms of physical and verbal abuse, including gynaecological and obstetric violence, as well as any other associated gender-based violence that may occur during the antenatal, childbirth and postnatal care periods. Such violence violates women's human rights and may constitute forms of gender-based violence. The European Parliamentary Assembly reaffirms its commitment to the promotion of gender equality in all areas, which will facilitate the prevention and eradication of all forms of violence against women, including obstetrical and gynaecological violence.

In April 2024, the European Parliament Committee on Women's Rights and Gender Equality (FEMM) identified the issue of obstetric and gynaecological violence as being situated at the convergence of two structural crises: gender-based violence and the under-resourcing of

healthcare systems. It can be argued that there are two key factors that contribute to the phenomenon of obstetric violence. The first can be linked to the evolution of medicine, in which there has been a tendency to pathologize women's bodies and to pursue a biomedical approach. The second factor is not the result of deliberate actions, but rather is embedded within the structure of the medical system[10]. From the perspective of the FEMM Committee, it is of the utmost importance to conceptualise obstetric and gynaecological violence as a systemic phenomenon. This approach is essential to facilitate recognition of its nature as a gender-based form of violence and to acknowledge that such acts are not always deliberate, but shaped by structural deficiencies inherent to healthcare systems.

In accordance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), particularly Article 12, it is mandatory for governments to implement comprehensive measures to eradicate discrimination against women in the domain of healthcare. This encompasses access to family planning services and all matters pertaining to pregnancy, childbirth and the postpartum period. Health services must guarantee women's prior informed consent, support their dignity, safeguard their privacy and consider their needs, perspectives and autonomy[11].

On the other hand, the Istanbul Convention of the Council of Europe does not explicitly delineate obstetric violence as a distinct form of violence against women. Despite the absence of explicit mention of obstetric violence as a form of gender-based violence, the Istanbul Convention includes forced marriage, female genital mutilation, forced abortion, and sterilisation within its scope.

10. European Parliament's Committee on Women's Rights and Gender Equality (FEMM), *Obstetric and gynaecological violence in the EU - Prevalence, legal frameworks and educational guidelines for prevention and elimination*, April 2024. Available at: *http://www.europarl.europa.eu/supporting-analyses* (accessed October 2024).

11. UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, December 18, 1979, United Nations, Treaty Series, Vol. 1249. Available at: *https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf* (accessed October 2024).

3. Should obstetric and gynaecological violence be considered a specific form of gender-based violence?

Over the course of centuries, childbirth and motherhood have been regarded as a duty for women, rather than as one of numerous potential roles. It was expected that women would contribute to society by reproducing and dedicating themselves to their families, husbands, and children.

These stereotypes have their roots in deeply entrenched religious, social, and cultural beliefs and ideas about femininity, sexuality, pregnancy, and motherhood. Such damaging stereotypes – in the context of the phenomenon of obstetric violence - are often reinforced by the assumption that childbirth should be a painful experience for women. The Bible phrase "with pain you will give birth" is emblematic of this pervasive societal mindset.

The focus is frequently on the health of the infant, with minimal consideration given to the mother's physical and emotional well-being. Maternity services are not immune to patriarchal influences. Women are encouraged to express positive sentiments about a healthy infant, while their own physical and emotional health is often undervalued.

Starting from these considerations, it can thus be argued that obstetric violence may constitute a form of gender-based violence that emerges from a patriarchal perspective of society, characterised by the subordination of women and the privileged status of men. This subordination can be observed in a number of different contexts, including both public and private spheres.

A significant proportion of instances of obstetric and gynaecological violence can be classified as gender-based violence.

1) Firstly, as some authors have suggested, to date no cisgender man has given birth. This indicates that the violence in question not only affects women disproportionately, but also exclusively[12].
2) Secondly, the lack of respect for women's equality and human rights,

12. S. Lévesque, A. Ferron-Parayre, *To Use or Not to Use the Term "Obstetric Violence": Commentary on the Article by Swartz and Lappeman*, in *Violence Against Women*, 2021, 27(8), 1009-1018. *https://doi.org/10.1177/1077801221996456*.

which can be identified as one of the primary causes of obstetric and gynaecological violence, represents a significant contributing factor to the phenomenon of violence against women in general. This suggests that there may be a common underlying cause of obstetric violence and gender-based violence.

3) Thirdly, patient-caregiver interactions frequently entail unequal power dynamics, where the caregiver possesses knowledge and authority over the patient, who is situated in a vulnerable position. This power imbalance, which is also characteristic of acts of gender-based violence, can result in the woman being placed in a submissive position.

However, the topic under consideration appears to be extremely complex, and, according to the authors, categorizing obstetric violence as a mere form of gender-based violence may not necessarily ensure an exhaustive analysis of the phenomenon, which is crucial to facilitate the development of effective solutions. This is because there are multiple factors that contribute to the intricate nature of the subject matter.

First of all, as already mentioned, it seems appropriate to conceptualise obstetric violence not merely in terms of the relationship between the individuals involved, but instead in terms of the relationship between the systems involved. In this case, it is essential to recognise the ways in which health and cultural systems interact and to understand the potential influences within them, which may, of course, have a sexist and gender-based component. However, reducing these influences to this one factor would be a limitation of the analysis.

Furthermore, it is also important to note that the healthcare professionals who perpetrate obstetric and gynaecological violence against women are not exclusively male (for instance, midwives are mostly women). Indeed, they are also more often female. In such instances, it becomes more challenging to discern the sexist and gender-based aspects of violent and disrespectful conducts during obstetrical and gynaecological procedures.

Moreover, it is crucial to recognise that the term "obstetric and gynaecological violence" should be regarded as an umbrella term that

encompasses a wide range of practices that are challenging to categorise within a single typology. The experiences and emotions that women have in relation to these violent experiences can also vary significantly[13]. Some women may experience feelings of dehumanisation, disrespect, or abuse, reporting instances of care that was insensitive and rude, which has resulted in increased psychological and emotional suffering. Such instances include cases in which patients have been made to feel insignificant, received dismissive comments regarding their pain, or been judged based on their age or body size. On the other hand, some women experienced instances of physical violation, including non-consensual cutting during childbirth or non-consensual insertion of fingers into the vagina. In these cases, women reported feelings of powerlessness and coercion, accompanied by a sense of impotence due to being uninformed or misinformed about the medical interventions performed.

Obstetric violence can manifest in various forms, including intentional or deliberate physical abuse (active forms), unintentional neglect due to staff shortages or overcrowding (passive forms), and issues related to the conditions of the healthcare system, such as for example a lack of beds that compromises basic privacy and confidentiality.

Nevertheless, all these various modalities have the potential to impact women's health, their experience of childbirth, and their right to respectful, dignified, and humane care. Pregnancy and childbirth are experiences that are unique to each woman and which have the potential to leave a profound and enduring impact on her life.

The central issue is whether it is appropriate to consider all the several different forms of obstetric and gynaecological violence as gender-based, or whether this characterisation is applicable only to some of them. In other words, is it possible to conclude that all practices within the domain of obstetric and gynaecological violence are inherently sexist in nature?

13. H. Keedle, W. Keedle *et al.*, *Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years*, in *Violence Against Women*, 2024, Jul; 30(9):2320-2344. DOI: 10.1177/10778012221140138. Epub 2022 Nov 30. PMID: 36452982; PMCID: PMC11145922.

In order to provide a systematic classification of the various practices that may fall under the category of "obstetric and gynaecological violence" and to ascertain whether they can be considered forms of gender-based violence, a classification of the main harmful practices reported in the literature has been proposed (see *Figure 1*). It should be noted that this classification is not intended to be exhaustive, and that the categories presented may overlap.

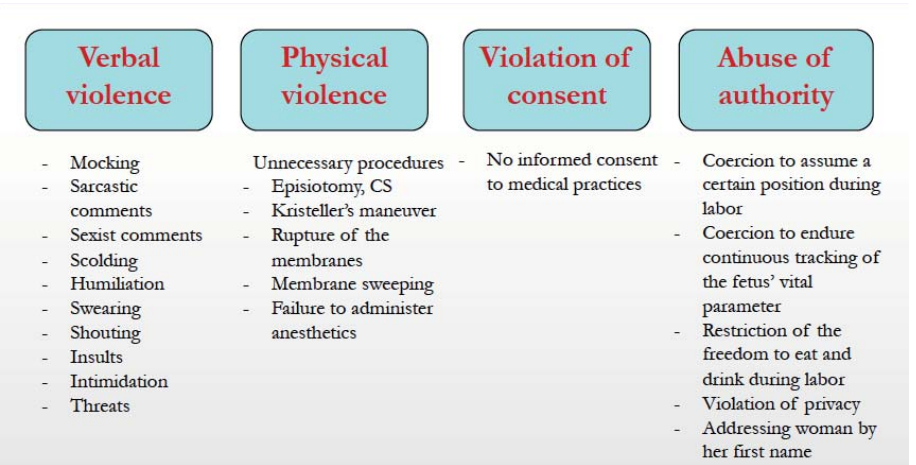

Fig. 1 – Classification of practices of Obstetric and Gynaecological Violence

In accordance with the proposed classification, four distinct categories of obstetric and gynaecological violence may be identified.

1) Acts of *Verbal violence*, defined as the use of words or language with the intention of inflicting emotional or psychological harm on another individual. This form of violence encompasses a range of behaviours, including mocking, sarcastic comments, sexist remarks, scolding, humiliation, swearing, shouting, insults, intimidation, threats, and other forms of verbal aggression in relation to situations of obstetric and/or gynaecological care.
2) Acts of *Physical violence* that are identified as causing suffering to women during childbirth, such as the performance of unnecessary surgical incisions (episiotomy, caesarean section), the application of Kristeller's manoeuvre, the detachment and rupture of the membranes, and the application of pressure to the abdomen.

The role of effective communication between professionals and women in this process appears to be a crucial contributing factor to the problem. Additionally, instances of omission that result in the woman experiencing pain are also included in this category. These instances include for example the failure to administer anaesthetics and painkillers.

3) Acts related to a "*Violations of consent*", referring to any procedures undertaken without prior, informed consent. At the time of admission for delivery, an informed consent is not requested. This may be viewed as an attempt to women's power, considering in particular that there is an alternative for delivery, i.e. a caesarean section. The decision on the mode of delivery (vaginal or caesarean) should be an informed decision of the woman.
4) Acts of "*Abuse of authority*", referring to a range of actions that may be perceived by women as oppressive or controlling, particularly in the context of healthcare. Such actions may include paternalistic medicine, coercive measures during the expulsive phase, limitations on the birthing mother's autonomy and ability to eat food during labour, and violations upon her privacy.

In consideration of the aforementioned distinctions between various forms of obstetric violence and their disparate emotional consequences, and returning to our initial question, it is thus pertinent to classify all these acts of obstetric and gynaecological violence as gender-based? Is it appropriate to make generalisations rather than distinguishing between specific situations?

It is the author's opinion that a one-size-fits-all approach is inappropriate in this context, and that not all forms of obstetric and gynaecological violence should be considered gender-based. Such an approach is of no benefit to women in their understanding and overcoming of the experiences they have undergone. Similarly, it is of no benefit to health professionals or policymakers in the development of effective strategies to address this harmful phenomenon. Furthermore, it may foster a sense of distrust in the healthcare system.

Unquestionably, it is possible to identify instances of obstetric and gynaecological violence that are based on gender violence. Such acts

frequently entail the utilisation of sexist language, verbal aggression, misogynistic attitudes, forced sterilisation, mutilation, denial of abortion, denial of a requested caesarean, a dearth of respect for women's equal status and medical paternalism. In Western countries, there is also the spread habit to host the partner in the box for the delivery, in most cases without requesting women's view. It is given for granted that the partner should assist. These elements are indicative of a pattern of victimisation that is typically experienced by women.

In contrast, institutional violence in the context of maternity care can be defined as violence perpetrated by healthcare professionals as a result of systemic issues, namely overwork, lack of privacy and insufficient time devoted to patients. It is important to note that this form of violence is not gender-based in nature.

A third area of concern is the phenomenon of medical malpractice, which can occur in instances where there is an inadequate informed consent to medical procedures – even when performed correctly – or when a procedure is conducted without a legitimate medical justification. Additionally, in such cases, instances of obstetric violence are not inherently gender-based.

It is important, in the author's view, to exercise caution when generalising and categorising obstetric violence as a mere form of gender-based violence. This is because different forms of obstetric violence may require different approaches.

In order to effectively address gender-based violence in obstetric settings, which undoubtedly exists, it is essential to implement policies that guarantee gender equality, challenge gender stereotypes, empower women and, most importantly, provide comprehensive training for healthcare professionals on gender and equity issues.

Conversely, in the context of institutional violence, it is necessary to prioritise the organisation of maternity facilities at the management level. This should entail addressing a range of health system issues, including understaffing, high patient volumes, low salaries, long working hours and a lack of infrastructure. In addition, there is a need to promote the importance of respectful care as an essential component of quality care. On the other hand, in the context of medical malpractice, the training of healthcare professionals, the use of only medically justified procedures,

and the importance of shared decision-making and informed consent are pivotal.

Furthermore, when addressing the issue for obstetric violence, searching for solutions, it is crucial to acknowledge the potential resistance of healthcare professionals to using the term "violence," including forms of gender-based violence, as it might imply a deliberate act of violence perpetrated by healthcare providers[14]. It is important to acknowledge that instances of mistreatment may be attributed to underlying systemic issues, a lack of training, misunderstanding, malpractice, or even negligence, as distinct from intentional violence. The implementation of effective strategies may be complicated by the fact that the term "violence" is often perceived as taboo by healthcare providers, and this can lead to resistance. This is due to the fact that the term is frequently employed in a manner that is perceived as offensive, which consequently results in its avoidance.

In addition, it seems pertinent to briefly address two contemporary forms of obstetric violence that can undoubtedly be attributed to gender-based inequality.

The first of these forms entails the denial or obstruction of access to legal abortion, which can ultimately result in harm to women or the performance of unsafe, illegal abortions[15]. Despite recent legislative developments in some countries that have expanded access to abortion, it remains illegal or subject to significant restrictions in numerous locations. In Italy, where legal abortion is guaranteed by legislation, women in some regions have limited access to the procedure due to a lack of hospitals that provide it. The criminalisation of abortion serves to reinforce patriarchal norms that penalise women for rejecting motherhood.

The second form concerns the practice of caesarean section on maternal request, in the absence of a medical indication. This raises the question of whether the refusal of a caesarean section on maternal request could be regarded as a form of gender-based obstetric violence,

14. F.A. Chervenak *et al.*, *Obstetric violence is a misnomer*, in *American Journal of Obstetrics & Gynecology*, Vol. 230, Issue 3, S1138-S1145.

15. E. O'Brien *et al.*, *Obstetric violence in historical perspective*, in *The Lancet*, Vol. 399, Issue 10342, 2183-2185.

and of whether this is a method of penalising women who decline natural childbirth.

4. Conclusions

From the author's perspective, it is an insufficient and inaccurate characterization of obstetric and gynaecological violence to view it as a mere form of gender-based violence. It would be inexact to claim that all instances of obstetric violence are rooted in sexism; this would be a reductionist view and an insufficient explanation of a complex phenomenon.

It is of the utmost importance to distinguish between the different forms of obstetric violence in order to develop targeted and effective solutions for each specific case. This necessitates a clear delineation between gender-based violence, institutional violence and medical malpractice.

It is evident that initiating a constructive and informed dialogue with healthcare professionals on the subject of gender stereotypes and the necessity of compassionate care is of paramount importance. Moreover, it is of the utmost importance to respect the principle of women's autonomy and to maintain a balance between this principle and the principle of beneficence, which also encompasses the foetus.

Appendix*
Regulating Ob-gyn Violence: Existing Laws Worldwide

edited by *Marilisa D'Amico* e *Costanza Nardocci*

* The Editors gratefully acknowledge the invaluable support and scholarly contribution of Dr. Sara Di Giovanni (PhD, Candidate, University of Milan) to the research and compilation of the Appendix.

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Ley N° 25.929
Parto Humanizado

Sancionada: 25 de agosto de 2004
Promulgada: 17 de septiembre de 2004
Publicada: B.O.: 21 de septiembre de 2004

Establécese que las obras sociales regidas por leyes nacionales y las entidades de medicina prepaga deberán brindar obligatoriamente determinadas prestaciones relacionadas con el embarazo, el trabajo de parto, el parto y el postparto, incorporándose las mismas al Programa

Médico Obligatorio. Derechos de los padres y de la persona recién nacida.

El Senado y Cámara de Diputados de la Nación Argentina reunidos en Congreso, etc. sancionan con fuerza de Ley:

Artículo 1º - La presente ley será de aplicación tanto al ámbito público como privado de la atención de la salud en el territorio de la Nación. Las obras sociales regidas por leyes nacionales y las entidades de medicina prepaga deberán brindar obligatoriamente las prestaciones establecidas en esta ley, las que quedan incorporadas de pleno derecho al Programa Médico Obligatorio.
Artículo 2º - Toda mujer, en relación con el embarazo, el trabajo de parto, el parto y el postparto, tiene los siguientes derechos:
a) A ser informada sobre las distintas intervenciones médicas que pudieren tener lugar durante esos procesos de manera que pueda optar libremente cuando existieren diferentes alternativas.
b) A ser tratada con respeto, y de modo individual y personalizado que le garantice la intimidad durante todo el proceso asistencial y tenga en consideración sus pautas culturales.
c) A ser considerada, en su situación respecto del proceso de nacimiento, como persona sana, de modo que se facilite su participación como protagonista de su propio parto.
d) Al parto natural, respetuoso de los tiempos biológico y psicológico, evitando prácticas invasivas y suministro de medicación que no estén justificados por el estado de salud de la parturienta o de la persona por nacer.
e) A ser informada sobre la evolución de su parto, el estado de su hijo o hija y, en general, a que se le haga partícipe de las diferentes actuaciones de los profesionales.
f) A no ser sometida a ningún examen o intervención cuyo propósito sea de investigación, salvo consentimiento manifestado por escrito bajo protocolo aprobado por el Comité de Bioética.
g) A estar acompañada, por una persona de su confianza y elección durante el trabajo de parto, parto y postparto.
h) A tener a su lado a su hijo o hija durante la permanencia en el establecimiento sanitario, siempre que el recién nacido no requiera de cuidados especiales.

i) A ser informada, desde el embarazo, sobre los beneficios de la lactancia materna y recibir apoyo para amamantar.
j) A recibir asesoramiento e información sobre los cuidados de sí misma y del niño o niña.
k) A ser informada específicamente sobre los efectos adversos del tabaco, el alcohol y las drogas sobre el niño o niña y ella misma.

Artículo 3º - Toda persona recién nacida tiene derecho:
a) A ser tratada en forma respetuosa y digna.
b) A su inequívoca identificación.
c) A no ser sometida a ningún examen o intervención cuyo propósito sea de investigación o docencia, salvo consentimiento, manifestado por escrito de sus representantes legales, bajo protocolo aprobado por el Comité de Bioética.
d) A la internación conjunta con su madre en sala, y a que la misma sea lo más breve posible, teniendo en consideración su estado de salud y el de aquélla.
e) A que sus padres reciban adecuado asesoramiento e información sobre los cuidados para su crecimiento y desarrollo, así como de su plan de vacunación.

Artículo 4º - El padre y la madre de la persona recién nacida en situación de riesgo tienen los siguientes derechos:
a) A recibir información comprensible, suficiente y continuada, en un ambiente adecuado, sobre el proceso o evolución de la salud de su hijo o hija, incluyendo diagnóstico, pronóstico y tratamiento.
b) A tener acceso continuado a su hijo o hija mientras la situación clínica lo permita, así como a participar en su atención y en la toma de decisiones relacionadas con su asistencia.
c) A prestar su consentimiento manifestado por escrito para cuantos exámenes o intervenciones se quiera someter al niño o niña con fines de investigación, bajo protocolo aprobado por el Comité de Bioética.
d) A que se facilite la lactancia materna de la persona recién nacida siempre que no incida desfavorablemente en su salud.
e) A recibir asesoramiento e información sobre los cuidados especiales del niño o niña.

Artículo 5º - Será autoridad de aplicación de la presente ley el Ministerio de Salud de la Nación en el ámbito de su competencia; y en las provincias y la Ciudad de Buenos Aires sus respectivas autoridades sanitarias.

Artículo 6º - El incumplimiento de las obligaciones emergentes de la presente ley, por parte de las obras sociales y entidades de medicina prepaga, como así también el incumplimiento por parte de los profesionales de la salud y sus colaboradores y de las instituciones en que éstos presten servicios, será considerado falta grave a los fines sancionatorios, sin perjuicio de la responsabilidad civil o penal que pudiere corresponder.

Artículo 7º - La presente ley entrará en vigencia a los SESENTA (60) días de su promulgación.

Artículo 8º - Comuníquese al Poder Ejecutivo.

GACETA OFICIAL DE LA REPÚBLICA BOLIVARIANA DE VENEZUELA
Caracas, lunes 23 de abril de 2007
Nº 38.668

LA ASAMBLEA NACIONAL DE LA REPÚBLICA BOLIVARIANA DE VENEZUELA
DECRETA
la siguiente,
LEY ORGÁNICA SOBRE EL DERECHO DE LAS MUJERES A UNA VIDA LIBRE DE VIOLENCIA

CAPÍTULO I: DISPOSICIONES GENERALES

Objeto
Artículo 1. - La presente Ley tiene por objeto garantizar y promover el derecho de las mujeres a una vida libre de violencia, creando condiciones para prevenir, atender, sancionar y erradicar la violencia contra las mujeres en cualquiera de sus manifestaciones y ámbitos, impulsando cambios en los patrones socioculturales que sostienen la desigualdad de género y las relaciones de poder sobre las mujeres, para favorecer la construcción de una sociedad justa democrática, participativa, paritaria y protagónica.

Principios rectores
Artículo 2. - A través de esta Ley se articula un conjunto integral de medidas para alcanzar los siguientes fines:
1. Garantizar a todas las mujeres, el ejercicio efectivo de sus derechos exigibles ante los órganos y entes de la Administración Pública, y asegurar un acceso rápido, transparente y eficaz a los servicios establecidos al efecto. 2. Fortalecer políticas públicas de prevención de la violencia contra las mujeres y de erradicación de la discriminación de género. Para ello, se dotarán a los Poderes Públicos de instrumentos eficaces en el ámbito educativo, laboral, de servicios sociales, sanitarios, publicitarios y mediáticos.
3. Fortalecer el marco penal y procesal vigente para asegurar una protección integral a las mujeres víctimas de violencia desde las instancias jurisdiccionales.
4. Coordinar los recursos presupuestarios e institucionales de los distintos Poderes Públicos para asegurar la atención, prevención y erradicación de los hechos de violencia contra las mujeres, así como la sanción adecuada a los culpables de los mismos y la implementación de medidas socioeducativas que eviten su reincidencia.
5. Promover la participación y colaboración de las entidades, asociaciones y organizaciones que actúan contra la violencia hacia las mujeres.
6. Garantizar el principio de transversalidad de las medidas de sensibilización, prevención, detección, seguridad y protección, de manera que en su aplicación se

tengan en cuenta los derechos, necesidades y demandas específicas de todas las mujeres víctimas de violencia de género.
7. Fomentar la especialización y la sensibilización de los colectivos profesionales que intervienen en el proceso de información, atención y protección de las mujeres víctimas de violencia de género.
8. Garantizar los recursos económicos, profesionales, tecnológicos, científicos y de cualquier otra naturaleza, que permitan la sustentabilidad de los planes, proyectos, programas, acciones, misiones y toda otra iniciativa orientada a la prevención, castigo y erradicación de la violencia contra las mujeres y el ejercicio pleno de sus derechos.
9. Establecer y fortalecer medidas de seguridad y protección, y medidas cautelares que garanticen los derechos protegidos en la presente Ley y la protección personal, física, emocional, laboral y patrimonial de la mujer víctima de violencia de género.
10. Establecer un sistema integral de garantías para el ejercicio de los derechos desarrollados en esta Ley.

Derechos protegidos
Artículo 3.- Esta Ley abarca la protección de los siguientes derechos:
1. El derecho a la vida.
2. La protección a la dignidad e integridad física, psicológica, sexual, patrimonial y jurídica de las mujeres víctimas de violencia, en los ámbitos público y privado.
3. La igualdad de derechos entre el hombre y la mujer.
4. La protección de las mujeres particularmente vulnerables a la violencia basada en género.
5. El derecho de las mujeres víctimas de violencia a recibir plena información y asesoramiento adecuado a su situación personal, a través de los servicios, organismos u oficinas que están obligadas a crear la Administración Pública, Nacional, Estadal y Municipal. Dicha información comprenderá las medidas contempladas en esta Ley relativas a su protección y seguridad, y los derechos y ayudas previstos en la misma, así como lo referente al lugar de prestación de los servicios de atención, emergencia, apoyo y recuperación integral.
6. Los demás consagrados en la Constitución de la República Bolivariana de Venezuela y en todos los convenios y tratados internacionales en la materia, suscritos por la República Bolivariana de Venezuela, tales como la Ley Aprobatoria de la Convención sobre la Eliminación de todas las Formas de Discriminación contra la Mujer (CEDAW) y la Convención Interamericana para Prevenir, Sancionar y Erradicar la Violencia contra la Mujer (Convención de Belem do Pará).

CAPÍTULO II: DE LAS GARANTÍAS PARA EL EJERCICIO DE LOS DERECHOS

De las garantías
Artículo 4. - Todas las mujeres con independencia de su nacionalidad, origen étnico, religión o cualquier otra condición o circunstancia personal, jurídica o social, dispondrán de los mecanismos necesarios para hacer efectivos los derechos reconocidos en esta Ley:

1. La información, la asistencia social integral y la asistencia jurídica a las mujeres en situación de violencia de género son responsabilidad del Estado venezolano.
2. En el caso de las mujeres que pertenezcan a los grupos especialmente vulnerables, el Instituto Nacional de la Mujer, así como los institutos regionales y municipales, debe asegurarse de que la información que se brinde a los mismos se ofrezca en formato accesible y comprensible, asegurándose el uso del castellano y de los idiomas indígenas, de otras modalidades u opciones de comunicación, incluidos los sistemas alternativos y aumentativos. En fin, se articularán los medios necesarios para que las mujeres en situación de violencia de género que por sus circunstancias personales y sociales puedan tener una mayor dificultad para el acceso integral a la información, tengan garantizado el ejercicio efectivo de este derecho.
3. Las mujeres víctimas de violencia de género tienen derecho a servicios sociales de atención, de emergencia, de protección, de apoyo y acogida y de recuperación integral. En cada estado y municipio se crearán dichos servicios, con cargo al presupuesto anual. La atención que presten dichos servicios deberá ser: permanente, urgente, especializada y multidisciplinaria profesionalmente y los mismos serán financiados por el Estado.
4. Los servicios enunciados en el numeral anterior actuarán coordinadamente y en colaboración con los órganos de seguridad ciudadana, los jueces y las juezas, los y las fiscales, los servicios sanitarios y la Defensoría Nacional de los Derechos de la Mujer. También tendrán derecho a la asistencia social integral a través de estos servicios sociales los niños, niñas y adolescentes que se encuentren bajo la potestad parental o responsabilidad de crianza de las mujeres víctimas de violencia.
5. El ente rector de las políticas públicas dirigidas hacia las mujeres, los institutos regionales y municipales de la mujer, así como las otras organizaciones, asociaciones o formas comunitarias que luchan por los derechos de las mujeres, orientarán y evaluarán los planes, proyectos, programas y acciones que se ejecuten, y emitirán recomendaciones para su mejora y eficacia.
6. La Defensoría del Pueblo, el Instituto Nacional de la Mujer y los institutos estadales, metropolitanos y municipales, velarán por la correcta aplicación de la presente Ley y de los instrumentos cónsonos con la misma. Corresponderá a la Defensoría Nacional de los Derechos de la Mujer y a las defensorías estadales, metropolitanas y municipales velar por el respeto y ejercicio efectivo del derecho a la justicia de las mujeres víctimas de violencia de género que acrediten insuficiencia de recursos para litigar, teniendo éstas derecho a la representación judicial y extrajudicial, y a que se les brinde el patrocinio necesario para garantizar la efectividad de los derechos aquí consagrados. Este derecho asistirá también a los y las causahabientes en caso de fallecimiento de la mujer agredida.
7. Los colegios de abogados y abogadas, de médicos y médicas, de psicólogos y psicólogas, de enfermeros y enfermeras de los distintos estados y distritos metropolitanos, deben establecer servicios gratuitos de asesoría especializada integral a las mujeres víctimas de violencia de género.
8. La trabajadora en situación de violencia de género tendrá derecho a la reducción o a la reordenación de su tiempo de trabajo, a ser movilizada geográficamente o al cambio de su centro de trabajo. Si su estado requiriere una suspensión laboral,

la misma deberá ser acreditada con la orden de protección del juez o de la jueza, previo informe y solicitud del Ministerio Público, bastando la acreditación de indicios. 9. El Estado desarrollará políticas públicas dirigidas a las mujeres víctimas de violencia que carezcan de trabajo, pudiendo ser insertadas en los programas, misiones y proyectos de capacitación para el empleo, según lo permitan las condiciones físicas y psicológicas en las cuales se encuentre. Si la mujer agredida tuviera una discapacidad reconocida oficialmente que le impida u obstaculice el acceso al empleo, recibirá una atención especial que permita su inserción laboral y su capacitación. Para ello se establecerán programas, proyectos y misiones. El Estado creará exenciones tributarias a las empresas, cooperativas y otros entes que promuevan el empleo, la inserción y reinserción en el mercado laboral y productivo de las mujeres víctimas de violencia de género.
10. Las mujeres víctimas de violencia de género tendrán prioridad para las ayudas y asistencias que cree la Administración Pública, Nacional, Estatal o Municipal. 11. Las mujeres víctimas de violencia de género tendrán prioridad en el acceso a la vivienda, a la tierra, al crédito y a la asistencia técnica en los planes gubernamentales.

Obligación del Estado
Artículo 5. - El Estado tiene la obligación indeclinable de adoptar todas las medidas administrativas, legislativas, judiciales y de cualquier otra índole que sean necesarias y apropiadas para asegurar el cumplimiento de esta Ley y garantizar los derechos humanos de las mujeres víctimas de violencia.

Participación de la sociedad
Artículo 6. - La sociedad tiene el derecho y el deber de participar de forma protagónica para lograr la vigencia plena y efectiva de la presente Ley, a través de las organizaciones comunitarias y sociales.

Educación y prevención
Artículo 7. - El Estado, con la activa participación de la sociedad, debe garantizar programas permanentes de educación y prevención sobre la violencia de género.

Principios procesales
Artículo 8. - En la aplicación e interpretación de esta Ley, deberán tenerse en cuenta los siguientes principios y garantías procesales:
1. Gratuidad: Las solicitudes, pedimentos, demandas y demás actuaciones relativas a los asuntos a que se refiere esta Ley, así como las copias certificadas que se expidan de las mismas se harán en papel común y sin estampillas. Los funcionarios y las funcionarias de los Poderes Públicos que en cualquier forma intervengan, los tramitarán con toda preferencia y no podrán cobrar emolumento ni derecho alguno.
2. Celeridad: Los órganos receptores de denuncias, auxiliares de la administración de justicia en los términos del artículo 111 del Código Orgánico Procesal Penal y los tribunales competentes, darán preferencia al conocimiento y trámite de los hechos previstos en esta Ley, sin dilación alguna, en los lapsos previstos en ella,

bajo apercibimiento de la medida administrativa que corresponda al funcionario o a la funcionaria que haya recibido la denuncia.
3. Inmediación: El juez o la jueza que ha de pronunciar la sentencia, debe presenciar la audiencia y la incorporación de las pruebas de las cuales obtiene su convencimiento, salvo en los casos que la Ley permita la comisión judicial para la evacuación de algún medio probatorio necesario para la demostración de los hechos controvertidos, cuyas resultas serán debatidas en la audiencia de juicio. Se apreciarán las pruebas que consten en el expediente debidamente incorporadas en la audiencia.
4. Confidencialidad: Los funcionarios y las funcionarias de los órganos receptores de denuncias, de las unidades de atención y tratamiento, y de los tribunales competentes, deberán guardar la confidencialidad de los asuntos que se sometan a su consideración.
5. Oralidad: Los procedimientos serán orales y sólo se admitirán las formas escritas previstas en esta Ley y en el Código Orgánico Procesal Penal.
6. Concentración: Iniciada la audiencia, ésta debe concluir en el mismo día. Si ello no fuere posible, continuará durante el menor número de días consecutivos.
7. Publicidad: El juicio será público, salvo que a solicitud de la mujer víctima de violencia el tribunal decida que éste se celebre total o parcialmente a puerta cerrada, debiendo informársele previa y oportunamente a la mujer, que puede hacer uso de este derecho.
8. Protección de las víctimas: Las víctimas de los hechos punibles aquí descritos tienen el derecho a acceder a los órganos especializados de justicia civil y penal de forma gratuita, expedita, sin dilaciones indebidas o formalismos inútiles, sin menoscabo de los derechos de las personas imputadas o acusadas. La protección de la víctima y la reparación del daño a las que tenga derecho serán también objetivo del procedimiento aquí previsto.

Medidas de Seguridad y Protección y Medidas Cautelares
Artículo 9. - Las medidas de seguridad y protección, y las medidas cautelares son aquellas que impone la autoridad competente señalada en esta Ley, para salvaguardar la vida, proteger la integridad física, emocional, psicológica y los bienes patrimoniales de las mujeres víctimas de violencia.

Supremacía de esta Ley
Artículo 10. - Las disposiciones de esta Ley serán de aplicación preferente por ser Ley Orgánica.

Fuero
Artículo 11. - En todos los delitos previstos en esta Ley no se reconocerá fuero especial, salvo los expresamente contenidos en la Constitución de la República Bolivariana de Venezuela y leyes de la República.

Preeminencia del Procedimiento Especial
Artículo 12. - El juzgamiento de los delitos de que trata esta Ley se seguirá por el procedimiento especial aquí previsto, salvo el supuesto especial contenido en el

parágrafo único del artículo 65, cuyo conocimiento corresponde a los tribunales penales ordinarios.

Intervención de equipo interdisciplinario
Artículo 13. - En la recepción de las denuncias y en la investigación procesal de los hechos de que trata esta Ley, se utilizará personal debidamente sensibilizado, concientizado y capacitado en violencia de género. Los respectivos despachos estarán dotados de salas de espera para personas imputadas, separadas de las destinadas para las víctimas.

CAPÍTULO III: DEFINICIÓN Y FORMAS DE VIOLENCIA CONTRA LAS MUJERES

Definición
Artículo 14. - La violencia contra las mujeres a que se refiere la presente Ley, comprende todo acto sexista que tenga o pueda tener como resultado un daño o sufrimiento físico, sexual, psicológico, emocional, laboral, económico o patrimonial; la coacción o la privación arbitraria de la libertad, así como la amenaza de ejecutar tales actos, tanto si se producen en el ámbito público como en el privado.

Formas de violencia
Artículo 15. - Se consideran formas de violencia de género en contra de las mujeres, las siguientes:
1. Violencia psicológica: Es toda conducta activa u omisiva ejercida en deshonra, descrédito o menosprecio al valor o dignidad personal, tratos humillantes y vejatorios, vigilancia constante, aislamiento, marginalización, negligencia, abandono, celotipia, comparaciones destructivas, amenazas y actos que conllevan a las mujeres víctimas de violencia a disminuir su autoestima, a perjudicar o perturbar su sano desarrollo, a la depresión e incluso al suicidio.
2. Acoso u hostigamiento: Es toda conducta abusiva y especialmente los comportamientos, palabras, actos, gestos, escritos o mensajes electrónicos dirigidos a perseguir, intimidar, chantajear, apremiar, importunar y vigilar a una mujer que pueda atentar contra su estabilidad emocional, dignidad, prestigio, integridad física o psíquica, o que puedan poner en peligro su empleo, promoción, reconocimiento en el lugar de trabajo o fuera de él.
3. Amenaza: Es el anuncio verbal o con actos de la ejecución de un daño físico, psicológico, sexual, laboral o patrimonial con el fin de intimidar a la mujer, tanto en el contexto doméstico como fuera de él.
4. Violencia física: Es toda acción u omisión que directa o indirectamente está dirigida a ocasionar un daño o sufrimiento físico a la mujer, tales como: Lesiones internas o externas, heridas, hematomas, quemaduras, empujones o cualquier otro maltrato que afecte su integridad física.
5. Violencia doméstica: Es toda conducta activa u omisiva, constante o no, de empleo de fuerza física o violencia psicológica, intimidación, persecución o amenaza contra la mujer por parte del cónyuge, el concubino, ex cónyuge, ex

concubino, persona con quien mantiene o mantuvo relación de afectividad, ascendientes, descendientes, parientes colaterales, consanguíneos y afines.
6. Violencia sexual: Es toda conducta que amenace o vulnere el derecho de la mujer a decidir voluntaria y libremente su sexualidad, comprendiendo ésta no sólo el acto sexual, sino toda forma de contacto o acceso sexual, genital o no genital, tales como actos lascivos, actos lascivos violentos, acceso carnal violento o la violación propiamente dicha.
7. Acceso carnal violento: Es una forma de violencia sexual, en la cual el hombre mediante violencias o amenazas, constriñe a la cónyuge, concubina, persona con quien hace vida marital o mantenga unión estable de hecho o no, a un acto carnal por vía vaginal, anal u oral, o introduzca objetos sea cual fuere su clase, por alguna de estas vías.
8. Prostitución forzada: Se entiende por prostitución forzada la acción de obligar a una mujer a realizar uno o más actos de naturaleza sexual por la fuerza o mediante la amenaza de la fuerza, o mediante coacción como la causada por el temor a la violencia, la intimidación, la opresión psicológica o el abuso del poder, esperando obtener o haber obtenido ventajas o beneficios pecuniarios o de otro tipo, a cambio de los actos de naturaleza sexual de la mujer.
9. Esclavitud sexual: Se entiende por esclavitud sexual la privación ilegítima de libertad de la mujer, para su venta, compra, préstamo o trueque con la obligación de realizar uno o más actos de naturaleza sexual.
10. Acoso sexual: Es la solicitud de cualquier acto o comportamiento de contenido sexual, para sí o para un tercero, o el procurar cualquier tipo de acercamiento sexual no deseado que realice un hombre prevaliéndose de una situación de superioridad laboral, docente o análoga, o con ocasión de relaciones derivadas del ejercicio profesional, y con la amenaza expresa o tácita de causarle a la mujer un daño relacionado con las legítimas expectativas que ésta pueda tener en el ámbito de dicha relación.
11. Violencia laboral: Es la discriminación hacia la mujer en los centros de trabajo: públicos o privados que obstaculicen su acceso al empleo, ascenso o estabilidad en el mismo, tales como exigir requisitos sobre el estado civil, la edad, la apariencia física o buena presencia, o la solicitud de resultados de exámenes de laboratorios clínicos, que supeditan la contratación, ascenso o la permanencia de la mujer en el empleo. Constituye también discriminación de género en el ámbito laboral quebrantar el derecho de igual salario por igual trabajo.
12. Violencia patrimonial y económica: Se considera violencia patrimonial y económica toda conducta activa u omisiva que directa o indirectamente, en los ámbitos público y privado, esté dirigida a ocasionar un daño a los bienes muebles o inmuebles en menoscabo del patrimonio de las mujeres víctimas de violencia o a los bienes comunes, así como la perturbación a la posesión o a la propiedad de sus bienes, sustracción, destrucción, retención o distracción de objetos, documentos personales, bienes y valores, derechos patrimoniales o recursos económicos destinados a satisfacer sus necesidades; limitaciones económicas encaminadas a controlar sus ingresos; o la privación de los medios económicos indispensables para vivir.

13. Violencia obstétrica: Se entiende por violencia obstétrica la apropiación del cuerpo y procesos reproductivos de las mujeres por personal de salud, que se expresa en un trato deshumanizador, en un abuso de medicalización y patologización de los procesos naturales, trayendo consigo pérdida de autonomía y capacidad de decidir libremente sobre sus cuerpos y sexualidad, impactando negativamente en la calidad de vida de las mujeres.
14. Esterilización forzada: Se entiende por esterilización forzada, realizar o causar intencionalmente a la mujer, sin brindarle la debida información, sin su consentimiento voluntario e informado y sin que la misma haya tenido justificación, un tratamiento médico o quirúrgico u otro acto que tenga como resultado su esterilización o la privación de su capacidad biológica y reproductiva.
15. Violencia mediática: Se entiende por violencia mediática la exposición, a través de cualquier medio de difusión, de la mujer, niña o adolescente, que de manera directa o indirecta explote, discrimine, deshonre, humille o que atente contra su dignidad con fines económicos, sociales o de dominación.
16. Violencia institucional: Son las acciones u omisiones que realizan las autoridades, funcionarios y funcionarias, profesionales, personal y agentes pertenecientes a cualquier órgano, ente o institución pública, que tengan como fin retardar, obstaculizar o impedir que las mujeres tengan acceso a las políticas públicas y ejerzan los derechos previstos en esta Ley para asegurarles una vida libre de violencia.
17. Violencia simbólica: Son mensajes, valores, iconos, signos que transmiten y reproducen relaciones de dominación, desigualdad y discriminación en las relaciones sociales que se establecen entre las personas y naturalizan la subordinación de la mujer en la sociedad.
18. Tráfico de mujeres, niñas y adolescentes: Son todos los actos que implican su reclutamiento o transporte dentro o entre fronteras, empleando engaños, coerción o fuerza, con el propósito de obtener un beneficio de tipo financiero u otro de orden material de carácter ilícito.
19. Trata de mujeres, niñas y adolescentes: Es la captación, el transporte, el traslado, la acogida o la recepción de mujeres, niñas y adolescentes, recurriendo a la amenaza o al uso de la fuerza o de otras formas de coacción, al rapto, al fraude, al engaño, al abuso de poder o de una situación de vulnerabilidad o la concesión o recepción de pagos o beneficios para obtener el consentimiento de una persona que tenga autoridad sobre mujeres, niñas o adolescentes, con fines de explotación, tales como prostitución, explotación sexual, trabajos o servicios forzados, la esclavitud o prácticas análogas a la esclavitud, la servidumbre o la extracción de órganos.

CAPÍTULO IV: DE LAS POLÍTICAS PÚBLICAS DE PREVENCIÓN Y ATENCIÓN

Definición y contenido
Artículo 16. - Las políticas públicas de prevención y atención son el conjunto de orientaciones y directrices dictadas por los órganos competentes, a fin de guiar las acciones dirigidas a asegurar los derechos y garantías consagrados en esta Ley.

Programas
Artículo 17. - Los programas son un conjunto articulado de acciones desarrolladas por personas naturales o jurídicas de naturaleza pública o privada, con fines de prevenir, detectar, monitorear, atender y erradicar la violencia en contra de las mujeres.

Corresponsabilidad
Artículo 18. - El Estado y la sociedad son corresponsables por la ejecución, seguimiento y control de las políticas de prevención y atención de la violencia contra las mujeres de conformidad con esta Ley. Corresponde al Instituto Nacional de la Mujer, como ente rector, formular las políticas de prevención y atención de la violencia contra las mujeres. El Ejecutivo Nacional dispondrá de los recursos necesarios para financiar planes, programas, proyectos y acciones de prevención y atención de la violencia de género, promovidos por los Consejos Comunales, las organizaciones de mujeres y otras organizaciones sociales de base.

Carácter vinculante
Artículo 19. - Las políticas públicas adoptadas conforme a esta Ley tienen carácter vinculante para todos los órganos de la Administración Pública, dentro de sus respectivos ámbitos de competencia.

Clasificación de los programas
Artículo 20. - Con el objeto de desarrollar políticas públicas y permitir la ejecución de las medidas a que se refiere la presente Ley, se establecen con carácter indicativo, los siguientes programas:
1. De prevención: para prevenir la ocurrencia de formas de violencia en contra de las mujeres, sensibilizando, formando y capacitando en derechos humanos e igualdad de género a la sociedad en su conjunto.
2. De sensibilización, adiestramiento, formación y capacitación: para satisfacer las necesidades de sensibilización y capacitación de las personas que se dediquen a la atención de las víctimas de violencia, así como las necesidades de adiestramiento y formación de quienes trabajen con los agresores.
3. De apoyo y orientación a las mujeres víctimas de violencia y su familia: para informarla, apoyarla en la adopción de decisiones asertivas y acompañamiento en el proceso de desarrollo de sus habilidades, para superar las relaciones interpersonales de control y sumisión, actuales y futuras.
4. De abrigo: para atender a las mujeres víctimas de violencia de género u otros integrantes de su familia que lo necesiten, en caso de la existencia de peligro inminente o amenaza a su integridad física.
5. Comunicacionales: para la difusión del derecho de la mujer a vivir libre de violencia.
6. De orientación y atención a la persona agresora: para promover cambios culturales e incentivar valores de respeto e igualdad entre hombres y mujeres que eviten la reincidencia de las personas agresoras.
7. Promoción y defensa: para permitir que las mujeres y los demás integrantes de las familias conozcan su derecho a vivir libres de violencia y de los medios para hacer efectivo este derecho.

8. Culturales: para la formación y respeto de los valores y la cultura de igualdad de género.

Atribuciones del Instituto Nacional de la Mujer
Artículo 21. - El Instituto Nacional de la Mujer, como órgano encargado de las políticas y programas de prevención y atención de la violencia contra las mujeres, tendrá las siguientes atribuciones:
1. Formular, orientar, ejecutar, coordinar e instrumentar las políticas públicas de prevención y atención para ser implementadas en los diferentes órganos del Poder Público Nacional, Estadal y Municipal, a los fines de conformar y articular el sistema integral de protección al que se refiere esta Ley.
2. Diseñar, conjuntamente con el ministerio con competencia en materia del interior y justicia y el Tribunal Supremo de Justicia, planes y programas de capacitación de los funcionarios y las funcionarias pertenecientes a la administración de justicia y al sistema penitenciario, y demás entes que intervengan en el tratamiento de los hechos de violencia que contempla esta Ley.
3. Diseñar, conjuntamente con los ministerios con competencia en materia de Salud y de Participación Popular y Desarrollo Social, planes, proyectos y programas de capacitación e información de los funcionarios y las funcionarias que realizan actividades de apoyo, servicios y atención médica y psicosocial para el tratamiento adecuado de las mujeres víctimas de violencia y de sus familiares, así como para el agresor.
4. Diseñar, conjuntamente con los ministerios con competencia en materia de Educación, Deporte, de Educación Superior, de Salud, de Participación y Desarrollo Social, de Comunicación e Información y con cualquier otro ente que tenga a su cargo funciones educativas, planes, proyectos y programas de prevención y educación dirigidos a formar para la igualdad, exaltando los valores de la no violencia, el respeto, la equidad de género y la preparación para la vida familiar con derechos y obligaciones compartidas y, en general, la igualdad entre el hombre y la mujer en la sociedad.
5. Promover la participación activa y protagónica de las organizaciones públicas y privadas dedicadas a la atención de la violencia contra las mujeres, así como de los Consejos Comunales y organizaciones sociales de base, en la definición y ejecución de las políticas públicas relacionadas con la materia regulada por esta Ley.
6. Llevar un registro de las organizaciones especializadas en la materia regulada por esta Ley, pudiendo celebrar con éstas convenios para la prevención, investigación y atención integral de las mujeres en situación de violencia y la orientación de los agresores.
7. Elaborar el proyecto de Reglamento de esta Ley.
8. Las demás que le señalan otras leyes y reglamentos.

Planes, programas y proyectos de capacitación del Tribunal Supremo de Justicia
Artículo 22. - El Tribunal Supremo de Justicia, a través de la Dirección Ejecutiva de la Magistratura y de la Escuela de la Magistratura, proveerá lo conducente para la ejecución de planes, programas y proyectos de capacitación en justicia

de género de los funcionarios y las funcionarias de la administración de justicia y de todas aquellas personas que intervengan en el tratamiento de los hechos que contempla esta Ley. La sensibilización, capacitación y formación la realizará el Tribunal Supremo de Justicia en coordinación con el Instituto Nacional de la Mujer, pudiendo suscribir convenios con las áreas de estudios de las mujeres y de género de las universidades. En los procedimientos previstos en esta Ley, los jueces y las juezas de las distintas instancias y jerarquía, incluyendo al Tribunal Supremo de Justicia, podrán solicitar la opinión de personas expertas en justicia de género.

Planes, proyectos y programas de capacitación por el Ministerio Público
Artículo 23. - El Ministerio Público deberá ejecutar planes, proyectos y programas especiales de formación en prevención y atención de la violencia de género, y transversalizar dichos programas con la perspectiva de género, en consonancia con la visión de los derechos humanos que consagra la Constitución de la República Bolivariana de Venezuela.

Atribuciones de los ministerios con competencia en materia de Educación y Deporte
Artículo 24. - Los ministerios con competencia en materia de educación y deporte deberán incorporar en los planes, proyectos y programas de estudio, en todos sus niveles y modalidades, contenidos, dirigidos a transmitir a los alumnos y alumnas, al profesorado y personal administrativo, los valores de la igualdad de género, el respeto, la mutua tolerancia, la autoestima, la comprensión, la solución pacífica de los conflictos y la preparación para la vida familiar y ciudadana, con derechos y obligaciones domésticas compartidas entre hombres y mujeres y, en general, la igualdad de condiciones entre los hombres y mujeres, niños, niñas y adolescentes. Asimismo, los ministerios con competencia en materia de educación y deporte, tomarán las medidas necesarias para excluir de los planes de estudio, textos y materiales de apoyo, todos aquellos estereotipos, criterios o valores que expresen cualquier tipo de discriminación o violencia en contra de las mujeres.

Atribuciones del ministerio con competencia en materia de Educación Superior
Artículo 25. - El ministerio con competencia en materia de educación superior, desarrollará acciones para transversalizar los pensa con la perspectiva de género y tomará las medidas necesarias para eliminar de los planes de estudio, textos, títulos otorgados, documentos oficiales y materiales de apoyo utilizados en las universidades, todos aquellos estereotipos, criterios o valores que expresen cualquier forma de discriminación. Así mismo, tomará las medidas necesarias para que las universidades incluyan en sus programas de pregrado y postgrado materias que aborden el tema de la violencia basada en género y promoverá el desarrollo de líneas de investigación en la materia.

Atribuciones del ministerio con competencia en materia del interior y justicia
Artículo 26. - El ministerio con competencia en materia del interior y justicia proveerá lo conducente para la ejecución de los planes y programas de capacitación

de los funcionarios y las funcionarias directamente involucrados e involucradas en la aplicación de la presente Ley. Dichos planes y programas deberán formularse y realizarse en coordinación con el Instituto Nacional de la Mujer y deben garantizar el adecuado trato y asistencia a las mujeres víctimas de violencia. Igualmente contemplará en sus planes, programas especiales para la atención y orientación de las personas agresoras. Establecerá además programas dirigidos a garantizar a las mujeres privadas de libertad el ejercicio de los derechos previstos en esta Ley.

Atribuciones del ministerio con competencia en materia de salud
Artículo 27. - El ministerio con competencia en materia de salud ejecutará los planes de capacitación e información, conjuntamente con el Instituto Nacional de la Mujer, para que el personal de salud que ejerce actividades de apoyo, de servicios y atención médica y psicosocial, actúe adecuadamente en la atención, investigación y prevención de los hechos previstos en esta Ley.

Programas de prevención en medios de difusión masiva
Artículo 28. - El ministerio con competencia en materia de infraestructura y el Consejo Nacional de Telecomunicaciones, de conformidad con la Ley de Responsabilidad Social en Radio y Televisión, supervisarán la efectiva inclusión de mensajes y programas destinados a prevenir y eliminar la violencia contra las mujeres en las programaciones de los medios de difusión masiva. A tal efecto, podrá establecer a las emisoras radiales y televisivas un tiempo mínimo gratuito para la transmisión de mensajes en contra de la violencia basada en género y de promoción de valores de igualdad entre los sexos.

Obligaciones de estados y municipios
Artículo 29. - Los estados y municipios, conforme a esta Ley, deberán coordinar con el Instituto Nacional de la Mujer y con los institutos regionales y municipales, las políticas, planes y programas a ejecutar para el desarrollo de las funciones de prevención y atención de la violencia contra la mujer en sus respectivas jurisdicciones.

Unidades de prevención, atención y tratamiento
Artículo 30. - El Ejecutivo Nacional, a través del órgano rector, coordinará con los órganos estadales y municipales el establecimiento de unidades especializadas de prevención de la violencia, así como centros de atención y tratamiento de las mujeres víctimas. Igualmente desarrollarán unidades de orientación que cooperarán con los órganos jurisdiccionales para el seguimiento y control de las medidas que le sean impuestas a las personas agresoras.

Atribuciones del Instituto Nacional de Estadística
Artículo 31. - El Instituto Nacional de Estadística, conjuntamente con el Instituto Nacional de la Mujer, coordinará con los organismos de los Poderes Públicos, los censos, estadísticas y cualquier otro estudio, permanente o no, que permita recoger datos desagregados de la violencia contra las mujeres en el territorio nacional.

Casas de abrigo
Artículo 32. - El Ejecutivo Nacional, Estadal y Municipal, con el fin de hacer más efectiva la protección de las mujeres en situación de violencia, con la asistencia, asesoría y capacitación del Instituto Nacional de la Mujer y de los institutos regionales y municipales de la mujer, crearán en cada una de sus dependencias casas de abrigo destinadas al albergue de las mismas, en los casos en que la permanencia en el domicilio o residencia implique amenaza inminente a su integridad.

CAPÍTULO V: DE LAS MUJERES VÍCTIMAS DE VIOLENCIA

Atención a las mujeres víctimas de violencia
Artículo 33. - Los órganos receptores de denuncias deberán otorgar a las mujeres víctimas de los hechos de violencia previstos en esta Ley, un trato digno de respeto y apoyo acorde a su condición de afectada, procurando facilitar al máximo su participación en los trámites en que deba intervenir. En consecuencia, deberán:
1. Asesorar a las mujeres víctimas de violencia sobre la importancia de preservar las evidencias.
2. Proveer a las mujeres agredidas información sobre los derechos que esta Ley le confiere y sobre los servicios gubernamentales o no gubernamentales disponibles para su atención y tratamiento.
3. Elaborar un informe de aquellas circunstancias que sirvan al esclarecimiento de los hechos, el cual deberá acompañar a la denuncia.
4. Cualquier otra información que los órganos receptores consideren importante señalarle a la mujer en situación de violencia para su protección.

Derechos laborales
Artículo 34. - Las trabajadoras o funcionarias víctimas de violencia tendrán derecho, en los términos previstos en las leyes respectivas, a la reducción o a la reordenación de su tiempo de trabajo, a la movilidad geográfica, al cambio de centro de trabajo, a la suspensión de la relación laboral con reserva de puesto de trabajo y a la excedencia en los términos que se determinen.

Parágrafo Único. Las ausencias totales o parciales al trabajo motivadas por la condición física o psicológica derivada de la violencia de género sufridas por las trabajadoras o funcionarias, se considerarán justificadas cuando así lo determinen los centros de atención de salud públicos o privados, en los términos previstos en la legislación respectiva.

Certificado Médico
Artículo 35. - A los fines de acreditar el estado físico de la mujer víctima de violencia, ésta podrá presentar un certificado médico expedido por profesionales de la salud que presten servicios en cualquier institución pública. De no ser posible, el certificado médico podrá ser expedido por una institución privada; en ambos casos, el mismo deberá ser conformado por un experto o una experta forense, previa solicitud del Ministerio Público.

Atención jurídica gratuita
Artículo 36. - En aquellos casos en que la víctima careciere de asistencia jurídica, podrá solicitar al juez o jueza competente la designación de un profesional o una profesional del derecho, quien la orientará debidamente y ejercerá la defensa de sus derechos desde los actos iniciales de la investigación. A tales efectos, el tribunal hará la selección de los abogados o las abogadas existentes, provenientes de la Defensoría Nacional de los Derechos de la Mujer, de las defensorías estadales y municipales, de los colegios de abogados y abogadas de cada jurisdicción o de cualquier organización pública o privada dedicada a la defensa de los derechos establecidos en esta Ley.

Intervención en el procedimiento
Artículo 37. - La persona agraviada, la Defensoría Nacional de los Derechos de la Mujer y las organizaciones sociales a que se refiere el numeral sexto del artículo 70 de esta Ley, podrán intervenir en el procedimiento aunque no se hayan constituido como querellantes.

De la solicitud de copias simples y certificadas
Artículo 38. - La mujer víctima de violencia podrá solicitar ante cualquier instancia copia simple o certificada de todas las actuaciones contenidas en la causa que se instruya por uno de los delitos tipificados en esta Ley, las que se le otorgarán en forma expedita, salvo el supuesto de reserva de las actuaciones a que se refiere el Código Orgánico Procesal Penal

CAPÍTULO VI: DE LOS DELITOS

Violencia psicológica
Artículo 39. - Quien mediante tratos humillantes y vejatorios, ofensas, aislamiento, vigilancia permanente, comparaciones destructivas o amenazas genéricas constantes, atente contra la estabilidad emocional o psíquica de la mujer, será sancionado con prisión de seis a dieciocho meses.

Acoso u hostigamiento
Artículo 40. - La persona que mediante comportamientos, expresiones verbales o escritas, o mensajes electrónicos ejecute actos de intimidación, chantaje, acoso u hostigamiento que atenten contra la estabilidad emocional, laboral, económica, familiar o educativa de la mujer, será sancionado con prisión de ocho a veinte meses.

Amenaza
Artículo 41. - La persona que mediante expresiones verbales, escritos o mensajes electrónicos amenace a una mujer con causarle un daño grave y probable de carácter físico, psicológico, sexual, laboral o patrimonial, será sancionado con prisión de diez a veintidós meses. Si la amenaza o acto de violencia se realizare en el domicilio o residencia de la mujer objeto de violencia, la pena se incrementará de un tercio a la mitad. Si el autor del delito fuere un funcionario público

perteneciente a algún cuerpo policial o militar, la pena se incrementará en la mitad. Si el hecho se cometiere con armas blancas o de fuego, la prisión será de dos a cuatro años.

Violencia física

Artículo 42. - El que mediante el empleo de la fuerza física cause un daño o sufrimiento físico a una mujer, hematomas, cachetadas, empujones o lesiones de carácter leve o levísimo, será sancionado con prisión de seis a dieciocho meses. Si en la ejecución del delito, la víctima sufriere lesiones graves o gravísimas, según lo dispuesto en el Código Penal, se aplicará la pena que corresponda por la lesión infringida prevista en dicho Código, más un incremento de un tercio a la mitad. Si los actos de violencia a que se refiere el presente artículo ocurren en el ámbito doméstico, siendo el autor el cónyuge, concubino, ex cónyuge, ex concubino, persona con quien mantenga relación de afectividad, aun sin convivencia, ascendiente, descendiente, pariente colateral, consanguíneo o afín de la víctima, la pena se incrementará de un tercio a la mitad. La competencia para conocer el delito de lesiones conforme lo previsto en este artículo corresponderá a los tribunales de violencia contra la mujer, según el procedimiento especial previsto en esta Ley.

Violencia Sexual

Artículo 43. - Quien mediante el empleo de violencias o amenazas constriña a una mujer a acceder a un contacto sexual no deseado que comprenda penetración por vía vaginal, anal u oral, aun mediante la introducción de objetos de cualquier clase por alguna de estas vías, será sancionado con prisión de diez a quince años. Si el autor del delito es el cónyuge, concubino, ex conyuge, ex concubino, persona con quien la víctima mantiene o mantuvo relación de afectividad, aun sin convivencia, la pena se incrementará de un cuarto a un tercio. El mismo incremento de pena se aplicará en los supuestos que el autor sea el ascendiente, descendiente, pariente colateral, consanguíneo o afín de la víctima. Si el hecho se ejecuta en perjuicio de una niña o adolescente, la pena será de quince a veinte años de prisión. Si la víctima resultare ser una niña o adolescente, hija de la mujer con quien el autor mantiene una relación en condición de cónyuge, concubino, ex cónyuge, ex concubino, persona con quien mantiene o mantuvo relación de afectividad, aún sin convivencia, la pena se incrementará de un cuarto a un tercio.

Acto carnal con víctima especialmente vulnerable

Artículo 44. - Incurre en el delito previsto en el artículo anterior y será sancionado con pena de quince a veinte años de prisión, quien ejecute el acto carnal, aun sin violencias o amenazas, en los siguientes supuestos:

1. En perjuicio de mujer vulnerable, en razón de su edad o en todo caso con edad inferior a trece años.
2. Cuando el autor se haya prevalido de su relación de superioridad o parentesco con la víctima, cuya edad sea inferior a los dieciséis años.
3. En el caso que la víctima se encuentre detenida o condenada y haya sido confiada a la custodia del agresor.

4. Cuando se tratare de una víctima con discapacidad física o mental o haya sido privada de la capacidad de discernir por el suministro de fármacos o sustancias psicotrópicas.

Actos lascivos
Artículo 45. - Quien mediante el empleo de violencias o amenazas y sin la intención de cometer el delito a que se refiere el artículo 43, constriña a una mujer a acceder a un contacto sexual no deseado, afectando su derecho a decidir libremente su sexualidad, será sancionado con prisión de uno a cinco años. Si el hecho se ejecuta en perjuicio de una niña o adolescente, la pena será de dos a seis años de prisión. En la misma pena incurrirá quien ejecute los actos lascivos en perjuicio de la niña o adolescente, aun sin violencias ni amenazas, prevaliéndose de su relación de autoridad o parentesco.

Prostitución forzada
Artículo 46. - Quien mediante el uso de la fuerza física, la amenaza de violencia, la coacción psicológica o el abuso de poder, obligue a una mujer a realizar uno o más actos de naturaleza sexual con el objeto de obtener a cambio ventajas de carácter pecuniario o de otra índole, en beneficio propio o de un tercero, será sancionado con pena de diez a quince años de prisión.

Esclavitud sexual
Artículo 47. - Quien prive ilegítimamente de su libertad a una mujer con fines de explotarla sexualmente mediante la compra, venta, préstamo, trueque u otra negociación análoga, obligándola a realizar uno o más actos de naturaleza sexual, será sancionado con pena de quince a veinte años de prisión.

Acoso sexual
Artículo 48. - El que solicitare a una mujer un acto o comportamiento de contenido sexual para sí o para un tercero o procurare un acercamiento sexual no deseado, prevaliéndose de una situación de superioridad laboral o docente o con ocasión de relaciones derivadas del ejercicio profesional, con la amenaza de causarle un daño relacionado con las legítimas expectativas que pueda tener en el ámbito de dicha relación, será sancionado con prisión de uno a tres años.

Violencia laboral
Artículo 49. - La persona que mediante el establecimiento de requisitos referidos a sexo, edad, apariencia física, estado civil, condición de madre o no, sometimiento a exámenes de laboratorio o de otra índole para descartar estado de embarazo, obstaculice o condicione el acceso, ascenso o la estabilidad en el empleo de las mujeres, será sancionado con multa de cien (100 U.T.) a mil unidades tributarias (1.000 U.T.), según la gravedad del hecho. Si se trata de una política de empleo de una institución pública o empresa del Estado, la sanción se impondrá a la máxima autoridad de la misma. En el supuesto de empresas privadas, franquicias o empresas transnacionales, la sanción se impondrá a quien ejerza la máxima representación en el país. La misma sanción se aplicará cuando mediante prácticas

administrativas, engañosas o fraudulentas se afecte el derecho al salario legal y justo de la trabajadora o el derecho a igual salario por igual trabajo.

Violencia patrimonial y económica
Artículo 50. - El cónyuge separado legalmente o el concubino en situación de separación de hecho debidamente comprobada, que sustraiga, deteriore, destruya, distraiga, retenga, ordene el bloqueo de cuentas bancarias o realice actos capaces de afectar la comunidad de bienes o el patrimonio propio de la mujer, será sancionado con prisión de uno a tres años. La misma pena se aplicará en el supuesto de que no exista separación de derecho, pero el autor haya sido sometido a la medida de protección de salida del hogar por un órgano receptor de denuncia o a una medida cautelar similar por el Tribunal de Control, Audiencia y Medidas competente. En el caso de que los actos a que se refiere el presente artículo estén dirigidos intencionalmente a privar a la mujer de los medios económicos indispensables para su subsistencia, o impedirle satisfacer sus necesidades y las del núcleo familiar, la pena se incrementará de un tercio a la mitad. Si el autor del delito a que se refiere el presente artículo, sin ser cónyuge ni concubino, mantiene o mantuvo relación de afectividad con la mujer, aun sin convivencia, la pena será de seis a doce meses de prisión. En los supuestos a que se refiere el presente artículo podrán celebrarse acuerdos reparatorios según lo dispuesto en el Código Orgánico Procesal Penal.

Violencia obstétrica
Artículo 51. - Se considerarán actos constitutivos de violencia obstétrica los ejecutados por el personal de salud, consistentes en: 1. No atender oportuna y eficazmente las emergencias obstétricas. 2. Obligar a la mujer a parir en posición supina y con las piernas levantadas, existiendo los medios necesarios para la realización del parto vertical. 3. Obstaculizar el apego precoz del niño o niña con su madre, sin causa médica justificada, negándole la posibilidad de cargarlo o cargarla y amamantarlo o amamantarla inmediatamente al nacer. 4. Alterar el proceso natural del parto de bajo riesgo, mediante el uso de técnicas de aceleración, sin obtener el consentimiento voluntario, expreso e informado de la mujer. 5. Practicar el parto por vía de cesárea, existiendo condiciones para el parto natural, sin obtener el consentimiento voluntario, expreso e informado de la mujer. En tales supuestos, el tribunal impondrá al responsable o la responsable, una multa de doscientas cincuenta (250 U.T.) a quinientas unidades tributarias (500 U.T.), debiendo remitir copia certificada de la sentencia condenatoria definitivamente firme al respectivo colegio profesional o institución gremial, a los fines del procedimiento disciplinario que corresponda.

Esterilización forzada
Artículo 52. - Quien intencionalmente prive a la mujer de su capacidad reproductiva, sin brindarle la debida información, ni obtener su consentimiento expreso, voluntario e informado, no existiendo razón médica o quirúrgica debidamente comprobada que lo justifique, será sancionado o sancionada con pena de prisión de dos a cinco años. El tribunal sentenciador remitirá copia de la

decisión condenatoria definitivamente firme al colegio profesional o institución gremial, a los fines del procedimiento disciplinario que corresponda.

Ofensa pública por razones de género
Artículo 53. - El o la profesional de la comunicación o que sin serlo, ejerza cualquier oficio relacionado con esa disciplina, y en el ejercicio de ese oficio u ocupación, ofenda, injurie, denigre de una mujer por razones de género a través de un medio de comunicación, deberá indemnizar a la mujer víctima de violencia con el pago de una suma no menor a doscientas (200 U.T.) ni mayor de quinientas unidades tributarias (500 U.T.) y hacer públicas sus disculpas por el mismo medio utilizado para hacer la ofensa y con la misma extensión de tiempo y espacio.

Violencia institucional
Artículo 54. - Quien en el ejercicio de la función pública, independientemente de su rango, retarde, obstaculice, deniegue la debida atención o impida que la mujer acceda al derecho a la oportuna respuesta en la institución a la cual ésta acude, a los fines de gestionar algún trámite relacionado con los derechos que garantiza la presente Ley, será sancionado con multa de cincuenta (50 U.T.) a ciento cincuenta unidades tributarias (150 U.T.). El tribunal competente remitirá copia certificada de la sentencia condenatoria definitivamente firme al órgano de adscripción del o la culpable, a los fines del procedimiento disciplinario que corresponda.

Tráfico ilícito de mujeres, niñas y adolescentes
Artículo 55. - Quien promueva, favorezca, facilite o ejecute la entrada o salida ilegal del país de mujeres, niñas o adolescentes, empleando engaños, coerción o fuerza con el fin de obtener un beneficio ilícito para sí o para un tercero, será sancionado o sancionada con pena de diez a quince años de prisión.

Trata de mujeres, niñas y adolescentes
Artículo 56. - Quien promueva, favorezca, facilite o ejecute la captación, transporte, la acogida o la recepción de mujeres, niñas o adolescentes, mediante violencias, amenazas, engaño, rapto, coacción u otro medio fraudulento, con fines de explotación sexual, prostitución, trabajos forzados, esclavitud, adopción irregular o extracción de órganos, será sancionado con prisión de quince a veinte años.

Obligación de aviso
Artículo 57. - El personal de salud que atienda a las mujeres víctimas de los hechos de violencia previstos en esta Ley, deberá dar aviso a cualesquiera de los organismos indicados en el artículo 71 de la misma, en el término de las veinticuatro horas siguientes por cualquier medio legalmente reconocido. Este plazo se extenderá a cuarenta y ocho horas, en el caso que no se pueda acceder a alguno de estos órganos por dificultades de comunicación. El incumplimiento de esta obligación se sancionará con multa de cincuenta (50 U.T.) a cien unidades tributarias (100 U.T.), por el tribunal a quien corresponda el conocimiento de la causa.

Obligación de tramitar debidamente la denuncia
Artículo 58. - Serán sancionados o sancionadas con la multa prevista en el artículo anterior, los funcionarios y funcionarias de los organismos a que se refiere el artículo 71 de esta Ley, que no tramitaren debidamente la denuncia dentro de las cuarenta y ocho horas siguientes a su recepción.

En virtud de la gravedad de los hechos podrá imponerse como sanción, la destitución del funcionario o la funcionaria.

Obligación de implementar correctivos
Artículo 59. - Toda autoridad jerárquica en centros de empleo, de educación o de cualquier otra índole, que en conocimiento de hechos de acoso sexual por parte de las personas que estén bajo su responsabilidad, no ejecute acciones adecuadas para corregir la situación y prevenir su repetición, será sancionada con multa de cincuenta (50 U.T.) a cien unidades tributarias (100 U.T.). El órgano jurisdiccional especializado competente estimará a los efectos de la imposición de la multa, la gravedad de los hechos y la diligencia que se ponga en la corrección de los mismos.

Reincidencia
Artículo 60. - Se considerará que hay reincidencia cuando después de una sentencia condenatoria definitivamente firme o luego de haberse extinguido la condena, el agresor cometiere un nuevo hecho punible de los previstos en esta Ley.

CAPÍTULO VII: DE LA RESPONSABILIDAD CIVIL

Indemnización
Artículo 61. - Todos los hechos de violencia previstos en esta Ley acarrearán el pago de una indemnización por parte del agresor a las mujeres víctimas de violencia o a sus herederos y herederas en caso de que la mujer haya fallecido como resultado de esos delitos, el monto de dicha indemnización habrá de ser fijado por el órgano jurisdiccional especializado competente, sin perjuicio de la obligación del agresor de pagar el tratamiento médico o psicológico que necesitare la víctima.

Reparación
Artículo 62. - Quien resultare condenado por los hechos punibles previstos en esta Ley, que haya ocasionado daños patrimoniales en los bienes muebles e inmuebles de las mujeres víctimas de violencia, estará obligado a repararlos con pago de los deterioros que hayan sufrido, los cuales serán determinados por el órgano jurisdiccional especializado competente. Cuando no sea posible su reparación, se indemnizará su pérdida pagándose el valor de mercado de dichos bienes.

Indemnización por acoso sexual
Artículo 63. - Quien resultare responsable de acoso sexual deberá indemnizar a la mujer víctima de violencia en los términos siguientes: 1. Por una suma igual al

doble del monto de los daños que el acto haya causado a la persona acosada en su acceso al empleo o posición que aspire, ascenso o desempeño de sus actividades. 2. Por una suma no menor de cien (100 U.T.) ni mayor de quinientas unidades tributarias (500 U.T.), en aquellos casos en que no se puedan determinar daños pecuniarios. Cuando la indemnización no pudiere ser satisfecha por el condenado motivado por estado de insolvencia debidamente acreditada, el tribunal de ejecución competente podrá hacer la conversión en trabajo comunitario a razón de un día de trabajo por cada unidad tributaria.

CAPÍTULO VIII: DISPOSICIONES COMUNES

Supletoriedad y complementariedad de normas
Artículo 64. - Se aplicarán supletoriamente las disposiciones del Código Penal y Código Orgánico Procesal Penal, en cuanto no se opongan a las aquí previstas. En los casos de homicidio intencional en todas sus calificaciones, tipificados en el Código Penal y el supuesto especial a que se refiere el parágrafo único del artículo 65 de la presente Ley, la competencia corresponde a los tribunales penales ordinarios conforme al procedimiento establecido en el Código Orgánico Procesal Penal. Sin embargo, los tribunales aplicarán las circunstancias agravantes aquí previstas cuando sean procedentes y, en general, observarán los principios y propósitos de la presente Ley.

Circunstancias agravantes
Artículo 65. - Serán circunstancias agravantes de los delitos previstos en esta Ley, las que se detallan a continuación, dando lugar a un incremento de la pena de un tercio a la mitad:
1. Penetrar en la residencia de la mujer agredida o en el lugar donde ésta habite, cuando la relación conyugal o marital de la mujer víctima de violencia con el acusado se encuentre en situación de separación de hecho o de derecho, o cuando el matrimonio haya sido disuelto mediante sentencia firme.
2. Penetrar en la residencia de la mujer víctima de violencia o en el lugar donde ésta habite, valiéndose del vínculo de consanguinidad o de afinidad.
3. Ejecutarlo con armas, objetos o instrumentos.
4. Ejecutarlo en perjuicio de una mujer embarazada.
5. Ejecutarlo en gavilla o con grupo de personas.
6. Si el autor del delito fuere un funcionario público en ejercicio de sus funciones.
7. Perpetrarlo en perjuicio de personas especialmente vulnerables, con discapacidad física o mental.
8. Que el acusado haya sido sancionado con sentencia definitivamente firme por la comisión de alguno de los delitos previstos en esta Ley.
9. Transmitir dolosamente a la mujer víctima de violencia infecciones o enfermedades que pongan en riesgo su salud. 10. Realizar acciones que priven a la víctima de la capacidad de discernir a consecuencia del empleo de medios fraudulentos o sustancias narcóticas o excitantes.
Parágrafo Único: En los casos de homicidio intencional en todas sus calificaciones, tipificados en el Código Penal, cuando el autor sea el cónyuge, ex conyuge,

concubino, ex concubino, persona con quien la víctima mantuvo vida marital, unión estable de hecho o relación de afectividad, con o sin convivencia, la pena a imponer será de veintiocho a treinta años de presidio.

Penas accesorias
Artículo 66. - En la sentencia condenatoria se establecerán expresamente las penas accesorias que sean aplicables en cada caso, de acuerdo con la naturaleza de los hechos objeto de condena. Son penas accesorias:
1. La interdicción civil durante el tiempo de la condena en los casos de penas de presidio.
2. La inhabilitación política mientras dure la pena.
3. La sujeción a la vigilancia de la autoridad por una quinta parte del tiempo de la condena, desde que ésta termine, la cual se cumplirá ante la primera autoridad civil del municipio donde reside.
4. La privación definitiva del derecho a la tenencia y porte de armas, sin perjuicio que su profesión, cargo u oficio sea policial, militar o de seguridad.
5. La suspensión o separación temporal del cargo o ejercicio de la profesión, cuando el delito se hubiese cometido en ejercicio de sus funciones o con ocasión de éstas, debiendo remitirse copia certificada de la sentencia al expediente administrativo laboral y al colegio gremial correspondiente, si fuera el caso.

Programas de orientación
Artículo 67. - Quienes resulten culpables de hechos de violencia en contra de las mujeres deberán participar obligatoriamente en programas de orientación, atención y prevención dirigidos a modificar sus conductas violentas y evitar la reincidencia. La sentencia condenatoria establecerá la modalidad y duración, conforme los límites de la pena impuesta.

Trabajo comunitario
Artículo 68. - Si la pena a imponer no excede de dieciocho meses de prisión y la persona condenada no es reincidente, el órgano jurisdiccional en funciones de ejecución, podrá sustituir la misma por trabajo o servicio comunitario, entendiéndose como tal, aquellas tareas de interés general que la persona debe realizar en forma gratuita, por un período que no podrá ser menor al de la sanción impuesta, cuya regularidad podrá establecer el tribunal sin afectar la asistencia de la persona a su jornada normal de trabajo o estudio. Las tareas a que se refiere este artículo deberán ser asignadas según las aptitudes ocupacionales de la persona que cumple la condena, en servicios comunitarios públicos, privados o mixtos.

Si la persona condenada no cumple con el trabajo comunitario, el Tribunal de Ejecución, previa audiencia con las partes, podrá ordenar el cumplimiento de la pena impuesta en la sentencia condenatoria. La ausencia de la mujer víctima de violencia en dicha audiencia no impedirá su realización.

Lugar de cumplimiento de la sanción
Artículo 69. - Los responsables por hechos de violencia cumplirán la sanción en el sitio de reclusión que designe el tribunal, el cual debe disponer de las condiciones

adecuadas para el desarrollo de los programas de tratamiento y orientación previstos en esta Ley.

CAPÍTULO IX: DEL INICIO DEL PROCESO
Sección Primera: De la Denuncia Legitimación para denunciar

Artículo 70. - Los delitos a que se refiere esta Ley podrán ser denunciados por:
1. La mujer agredida.
2. Los parientes consanguíneos o afines.
3. El personal de la salud de instituciones públicas y privadas que tuviere conocimiento de los casos de violencia previstos en esta Ley.
4. Las defensorías de los derechos de la mujer a nivel nacional, metropolitano, estadal y municipal, adscritas a los institutos nacionales, metropolitanos, regionales y municipales, respectivamente.
5. Los Consejos Comunales y otras organizaciones sociales.
6. Las organizaciones defensoras de los derechos de las mujeres.
7. Cualquier otra persona o institución que tuviere conocimiento de los hechos punibles previstos en esta Ley.

Órganos receptores de denuncia
Artículo 71. - La denuncia a que se refiere el artículo anterior podrá ser formulada en forma oral o escrita, con o sin la asistencia de un abogado o abogada, ante cualesquiera de los siguientes organismos:
1. Ministerio Público.
2. Juzgados de Paz.
3. Prefecturas y jefaturas civiles.
4. División de Protección en materia de niño, niña, adolescente, mujer y familia del cuerpo de investigación con competencia en la materia.
5. Órganos de policía.
6. Unidades de comando fronterizas.
7. Tribunales de municipios en localidades donde no existan los órganos anteriormente nombrados.
8. Cualquier otro que se le atribuya esta competencia. Cada uno de los órganos anteriormente señalados deberá crear oficinas con personal especializado para la recepción de denuncias de los hechos de violencia a que se refiere esta Ley.
Parágrafo Único: Los pueblos y comunidades indígenas constituirán órganos receptores de denuncia, integrados por las autoridades legítimas de acuerdo con sus costumbres y tradiciones, sin perjuicio de que la mujer agredida pueda acudir a los otros órganos indicados en el presente artículo.

Obligaciones del órgano receptor de la denuncia
Artículo 72. - El órgano receptor de la denuncia deberá:
1. Recibir la denuncia, la cual podrá ser presentada en forma oral o escrita.
2. Ordenar las diligencias necesarias y urgentes, entre otras, la práctica de los exámenes médicos correspondientes a la mujer agredida en los centros de salud pública o privada de la localidad.

3. Impartir orientación oportuna a la mujer en situación de violencia de género.
4. Ordenar la comparecencia obligatoria del presunto agresor, a los fines de la declaración correspondiente y demás diligencias necesarias que permitan el esclarecimiento de los hechos denunciados.
5. Imponer las medidas de protección y de seguridad pertinentes establecidas en esta Ley.
6. Formar el respectivo expediente.
7. Elaborar un informe de aquellas circunstancias que sirvan al esclarecimiento de los hechos, el cual deberá acompañar a la denuncia, anexando cualquier otro dato o documento que sea necesario a juicio del órgano receptor de la denuncia.
8. Remitir el expediente al Ministerio Público.

Contenido del expediente
Artículo 73. - El expediente que se forme habrá de contar con una nomenclatura consecutiva y deberá estar debidamente sellado y foliado, debiendo además contener: 1. Acta de denuncia en la que se explique la forma en que ocurrieron los hechos de violencia, haciendo mención expresa del lugar, hora y fecha en que fue agredida la persona denunciante, así como la fecha y hora en que interpone la denuncia.
2. Datos de identidad de la persona señalada como agresora y su vínculo con la mujer víctima de violencia.
3. Información sobre hechos de violencia que le hayan sido atribuidos al presunto agresor, especificando si fuere posible, la fecha en que ocurrieron, y si hubo denuncia formal ante un órgano receptor competente.
4. Constancia del estado de los bienes muebles o inmuebles afectados de propiedad de la mujer víctima, cuando se trate de violencia patrimonial.
5. Boleta de notificación al presunto agresor.
6. Constancias de cada uno de los actos celebrados, pudiendo ser esto corroborado mediante las actas levantadas a tales efectos, debidamente firmadas por las partes y el funcionario o la funcionaria del órgano receptor.
7. Constancia de remisión de la mujer agredida al examen médico pertinente.
8. Resultado de las experticias, exámenes o evaluaciones practicadas a la mujer víctima de violencia y al presunto agresor.
9. Especificación de las medidas de protección de la mujer víctima de violencia con su debida fundamentación.

Responsabilidad del funcionario receptor o de la funcionaria receptora
Artículo 74. - El funcionario o la funcionaria que actúe como órgano receptor iniciará y sustanciará el expediente, aun si faltare alguno de los recaudos, y responderá por su omisión o negligencia, civil, penal y administrativamente, según los casos, sin que les sirvan de excusa órdenes superiores.

Sección Segunda: De la Investigación Objeto
Artículo 75. - La investigación tiene por objeto hacer constar la comisión de un hecho punible, las circunstancias que incidan en su calificación, la recolección y preservación de las evidencias relacionadas con su perpetración, la identificación

del presunto autor u autores del delito y los elementos que fundamentan su culpabilidad.

Competencia
Artículo 76. - El o la Fiscal del Ministerio Público especializado o especializada dirigirá la investigación en casos de hechos punibles y será auxiliado o auxiliada por los cuerpos policiales. De la apertura de la investigación se notificará de inmediato al Tribunal de Violencia contra la Mujer en Funciones de Control, Audiencia y Medidas.

Alcance
Artículo 77. - El Ministerio Público debe investigar y hacer constar tanto los hechos y circunstancias útiles para el ejercicio de la acción, como aquellos que favorezcan a la defensa del imputado o imputada.

Derechos del imputado
Artículo 78. - Durante la investigación, el imputado tendrá los derechos establecidos en la Constitución de la República Bolivariana de Venezuela, el Código Orgánico Procesal Penal y la presente Ley.

Lapso para la investigación
Artículo 79. - El Ministerio Público dará término a la investigación en un plazo que no excederá de cuatro meses. Si la complejidad del caso lo amerita, el Ministerio Público podrá solicitar fundadamente ante el Tribunal de Violencia Contra la Mujer con funciones de Control, Audiencia y Medidas, competente, con al menos diez días de antelación al vencimiento de dicho lapso, una prórroga que no podrá ser menor de quince ni mayor de noventa días. El Tribunal decidirá, mediante auto razonado, dentro de los tres días hábiles siguientes a la solicitud fiscal. La decisión que acuerde o niegue la prórroga podrá ser apelada en un solo efecto. Parágrafo Único: En el supuesto de que el Tribunal de Control, Audiencia y Medidas haya decretado la privación de libertad en contra del imputado e imputada, el Ministerio Público presentará el acto conclusivo correspondiente dentro de los treinta días siguientes a la decisión judicial. Este lapso podrá ser prorrogado por un máximo de quince días, previa solicitud fiscal debidamente fundada y presentada con al menos cinco días de anticipación a su vencimiento. El juez o la jueza decidirá lo procedente dentro de los tres días siguientes. Vencido el lapso sin que el o la fiscal presente el correspondiente acto conclusivo, el Tribunal acordará la libertad del imputado o imputada e impondrá una medida cautelar sustitutiva o alguna de las medidas de protección y seguridad a que se refiere la presente Ley.

Libertad de Prueba
Artículo 80. - Salvo prohibición de la ley, las partes pueden promover todas las pruebas conducentes al mejor esclarecimiento de los hechos, las cuales serán valoradas según la sana crítica, observando las reglas de la lógica, los conocimientos científicos y las máximas de experiencia. La prueba de careo sólo podrá realizarse a petición de la víctima.

Juzgados de Control, Audiencia y Medidas
Artículo 81. - Los Juzgados de violencia contra la mujer en funciones de Control, Audiencia y Medidas son los competentes para autorizar y realizar pruebas anticipadas, acordar medidas de coerción personal, resolver incidencias, excepciones y peticiones de las partes durante esta fase y velar por el cumplimiento de los derechos y garantías previstos en la Constitución de la República Bolivariana de Venezuela, el Código Orgánico Procesal Penal, la presente Ley y el ordenamiento jurídico en general.

Sección Tercera: De la Querella

Querella
Artículo 82. - Podrán promover querella las mujeres víctimas de violencia de cualesquiera de los hechos señalados en esta Ley, o sus familiares hasta el cuarto grado de consanguinidad y segundo de afinidad, cuando ésta se encuentre legal o físicamente imposibilitada de ejercerla.

Formalidad
Artículo 83. - La querella se presentará por escrito ante el Tribunal de Violencia contra la Mujer en funciones de Control, Audiencia y Medidas.

Contenido
Artículo 84. - La querella contendrá:
1. El nombre, apellido, edad, estado, profesión, domicilio o residencia de la persona querellante, y sus relaciones de parentesco con la persona querellada.
2. El nombre, apellido, edad, domicilio o residencia de la persona querellada.
3. El delito que se le imputa, el lugar, día y hora aproximada de su perpetración.
4. Una relación especificada de todas las circunstancias esenciales del hecho.

Diligencias del Querellante
Artículo 85. - La persona querellante podrá solicitar a el o a la fiscal las diligencias que estime necesarias para la investigación de los hechos.

Incidencias de la Querella
Artículo 86. - La admisibilidad, rechazo, oposición, desistimiento y demás incidencias relacionadas con la querella se tramitarán conforme a lo dispuesto en el Código Orgánico Procesal Penal.

Sección Cuarta: De las Medidas de Protección y de Seguridad

Medidas de protección y de seguridad
Artículo 87. - Las medidas de protección y de seguridad son de naturaleza preventiva para proteger a la mujer agredida en su integridad física, psicológica, sexual y patrimonial, y de toda acción que viole o amenace a los derechos contemplados en esta Ley, evitando así nuevos actos de violencia y serán de

aplicación inmediata por los órganos receptores de denuncias. En consecuencia, éstas serán:
1. Referir a las mujeres agredidas que así lo requieran, a los centros especializados para que reciban la respectiva orientación y atención.
2. Tramitar el ingreso de las mujeres víctimas de violencia, así como de sus hijos e hijas que requieran protección a las casas de abrigo de que trata el artículo 32 de esta Ley. En los casos en que la permanencia en su domicilio o residencia, implique amenaza inminente o violación de derechos previstos en esta Ley. La estadía en las casas de abrigo tendrá carácter temporal.
3. Ordenar la salida del presunto agresor de la residencia común, independientemente de su titularidad, si la convivencia implica un riesgo para la seguridad integral: física, psíquica, patrimonial o la libertad sexual de la mujer, impidiéndole que retire los enseres de uso de la familia, autorizándolo a llevar sólo sus efectos personales, instrumentos y herramientas de trabajo. En caso de que el denunciado se negase a cumplir con la medida, el órgano receptor solicitará al Tribunal competente la confirmación y ejecución de la misma, con el auxilio de la fuerza pública.
4. Reintegrar al domicilio a las mujeres víctimas de violencia, disponiendo la salida simultánea del presunto agresor, cuando se trate de una vivienda común, procediendo conforme a lo establecido en el numeral anterior.
5. Prohibir o restringir al presunto agresor el acercamiento a la mujer agredida; en consecuencia, imponer al presunto agresor la prohibición de acercarse al lugar de trabajo, de estudio y residencia de la mujer agredida.
6. Prohibir que el presunto agresor, por sí mismo o por terceras personas, no realice actos de persecución, intimidación o acoso a la mujer agredida o algún integrante de su familia.
7. Solicitar al órgano jurisdiccional competente la medida de arresto transitorio.
8. Ordenar el apostamiento policial en el sitio de residencia de la mujer agredida por el tiempo que se considere conveniente.
9. Retener las armas blancas o de fuego y el permiso de porte, independientemente de la profesión u oficio del presunto agresor, procediendo a la remisión inmediata al órgano competente para la práctica de las experticias que correspondan.
10. Solicitar al órgano con competencia en la materia de otorgamiento de porte de armas, la suspensión del permiso de porte cuando exista una amenaza para la integridad de la víctima.
11. Imponer al presunto agresor la obligación de proporcionar a la mujer víctima de violencia el sustento necesario para garantizar su subsistencia, en caso de que ésta no disponga de medios económicos para ello y exista una relación de dependencia con el presunto agresor. Esta obligación no debe confundirse con la obligación alimentaria que corresponde a los niños, niñas y adolescentes, y cuyo conocimiento compete al Tribunal de Protección.
12. Solicitar ante el juez o la jueza competente la suspensión del régimen de visitas al presunto agresor a la residencia donde la mujer víctima esté albergada junto con sus hijos o hijas.
13. Cualquier otra medida necesaria para la protección de todos los derechos de las mujeres víctimas de violencia y cualquiera de los integrantes de la familia.

Subsistencia de las Medidas de Protección y de Seguridad
Artículo 88. - En todo caso, las medidas de protección subsistirán durante el proceso y podrán ser sustituidas, modificadas, confirmadas o revocadas por el órgano jurisdiccional competente, bien de oficio o a solicitud de parte. La sustitución, modificación, confirmación o revocación de las medidas de protección procederá en caso de existir elementos probatorios que determinen su necesidad.

Aplicación preferente de las medidas de seguridad y protección y de las medidas cautelares
Artículo 89. - Las medidas de seguridad y protección y las medidas cautelares establecidas en la presente Ley, serán de aplicación preferente a las establecidas en otras disposiciones legales, sin perjuicio que el juez o la jueza competente, de oficio, a petición fiscal o a solicitud de la víctima, estime la necesidad de imponer alguna de las medidas cautelares sustitutivas previstas en el Código Orgánico Procesal Penal con la finalidad de garantizar el sometimiento del imputado o acusado al proceso seguido en su contra.

Trámite en caso de necesidad y urgencia
Artículo 90. - El órgano receptor, en casos de necesidad y urgencia, podrá solicitar directamente al Tribunal de Violencia contra la Mujer en Funciones de Control, Audiencia y Medidas la respectiva orden de arresto. La resolución que ordena el arresto será siempre fundada. El tribunal deberá decidir dentro de las veinticuatro horas siguientes a la solicitud.

Disposiciones Comunes sobre las Medidas de Protección y Seguridad
Artículo 91. - El Tribunal de Violencia contra la Mujer en funciones de Control, Audiencia y Medidas, podrá:
1. Sustituir, modificar, confirmar o revocar las medidas de protección impuestas por el órgano receptor.
2. Acordar aquellas medidas solicitadas por la mujer víctima de violencia o el Ministerio Público.
3. Imponer cualquier otra medida de las previstas en los artículos 87 y 92, de acuerdo con las circunstancias que el caso presente.
Parágrafo Primero: Si la urgencia del caso lo amerita no será requisito para imponer la medida, el resultado del examen médico correspondiente, pudiendo subsanarse con cualquier otro medio probatorio que resulte idóneo, incluyendo la presencia de la mujer víctima de violencia en la audiencia.

Medidas cautelares
Artículo 92. - El Ministerio Público podrá solicitar al Tribunal de Violencia contra la Mujer en funciones de Control, Audiencia y Medidas, o en funciones de juicio, si fuere el caso, las siguientes medidas cautelares:
1. Arresto transitorio del agresor hasta por cuarenta y ocho horas que se cumplirá en el establecimiento que el tribunal acuerde.
2. Orden de prohibición de salida del país del presunto agresor, cuyo término lo fijará el tribunal de acuerdo con la gravedad de los hechos.

3. Prohibición de enajenar y gravar bienes de la comunidad conyugal o concubinaria, hasta un cincuenta por ciento (50%).
4. Prohibición para el presunto agresor de residir en el mismo municipio donde la mujer víctima de violencia haya establecido su nueva residencia, cuando existan evidencias de persecución por parte de éste.
5. Allanamiento del lugar donde se cometieron los hechos de violencia.
6. Fijar una obligación alimentaria a favor de la mujer víctima de violencia, previa evaluación socioeconómica de ambas partes.
7. Imponer al presunto agresor la obligación de asistir a un centro especializado en materia de violencia de género.
8. Cualquier otra medida necesaria para la protección personal, física, psicológica y patrimonial de la mujer víctima de violencia.

Sección Quinta: De la Aprehensión en flagrancia

Definición y forma de proceder
Artículo 93. - Se tendrá como flagrante todo delito previsto en esta Ley que se esté cometiendo o el que acaba de cometerse. También se tendrá como flagrante aquél por el cual el agresor sea perseguido por la autoridad policial, por la mujer agredida, por un particular o por el clamor público, o cuando se produzcan solicitudes de ayuda a servicios especializados de atención a la violencia contra las mujeres, realizadas a través de llamadas telefónicas, correos electrónicos o fax, que permitan establecer su comisión de manera inequívoca, o en el que se sorprenda a poco de haberse cometido el hecho, en el mismo lugar o cerca del lugar donde se cometió, con armas, instrumentos u objetos que de alguna manera hagan presumir con fundamento que él es el autor.

En estos casos, toda autoridad deberá y cualquier particular podrá, aprehender al agresor. Cuando la aprehensión la realizare un particular, deberá entregarlo inmediatamente a la autoridad más cercana, quien en todo caso lo pondrá a disposición del Ministerio Público dentro de un lapso que no excederá de doce horas a partir del momento de la aprehensión.

Se entenderá que el hecho se acaba de cometer cuando la víctima u otra persona que haya tenido conocimiento del hecho, acuda dentro de las veinticuatro horas siguientes a la comisión del hecho punible al órgano receptor y exponga los hechos de violencia relacionados con esta Ley. En este supuesto, conocida la comisión del hecho punible el órgano receptor o la autoridad que tenga conocimiento, deberá dirigirse en un lapso que no debe exceder de las doce horas, hasta el lugar donde ocurrieron los hechos, recabará los elementos que acreditan su comisión y verificados los supuestos a que se refiere el presente artículo, procederá a la aprehensión del presunto agresor, quien será puesto a la disposición del Ministerio Público, según el párrafo anterior.

El Ministerio Público, en un término que no excederá de las cuarenta y ocho horas contadas a partir de la aprehensión del presunto agresor, lo deberá presentar ante el Tribunal de Violencia Contra la Mujer en Funciones de Control, Audiencia y Medidas, el cual, en audiencia con las partes y la víctima, si ésta estuviere presente, resolverá si mantiene la privación de libertad o la sustituye por otra menos gravosa.

La decisión deberá ser debidamente fundada y observará los supuestos de procedencia para la privación de libertad contenidos en el Código Orgánico Procesal Penal, ajustados a la naturaleza de los delitos contenidos en la presente Ley, según el hecho de que se trate y atendiendo a los objetivos de protección de las víctimas, sin menoscabo de los derechos del presunto agresor.

Sección Sexta: Del Procedimiento Especial

Trámite
Artículo 94. - El juzgamiento de los delitos de que trata esta Ley se seguirá por el procedimiento especial aquí estipulado, aun en los supuestos de flagrancia previstos en el artículo anterior, con la salvedad consagrada en el parágrafo único del artículo 79, para el supuesto en que haya sido decretada medida privativa de libertad en contra del presunto agresor.

Formas de inicio del procedimiento
Artículo 95. - La investigación de un hecho que constituya uno de los delitos previstos en esta Ley, se iniciará de oficio, por denuncia oral, escrita o mediante querella interpuesta por ante el órgano jurisdiccional competente.

Todos estos delitos son de acción pública; sin embargo, para el inicio de la investigación en los supuestos a que se refieren los artículos 39, 40, 41, 48, 49 y 53 se requiere la denuncia del hecho por las personas o instituciones legitimadas para formularla.

Investigación del Ministerio Público
Artículo 96. - Cuando el Ministerio Público tuviere conocimiento de la comisión de un hecho punible de los previstos en esta Ley, sin pérdida de tiempo ordenará el inicio de la investigación y dispondrá que se practiquen todas las diligencias necesarias que correspondan para demostrar la comisión del hecho punible, así como la responsabilidad penal de las personas señaladas como autores o partícipes, imponiendo inmediatamente las medidas de protección y seguridad que el caso amerite.

Del inicio ante otro órgano receptor
Artículo 97. - Cuando la denuncia o averiguación de oficio es conocida por un órgano receptor distinto al Ministerio Público, éste procederá a dictar las medidas de protección y seguridad que el caso amerite y a notificar de inmediato a el o a la Fiscal del Ministerio Público correspondiente, para que dicte la orden de inicio de la investigación, practicará todas las diligencias necesarias que correspondan para acreditar la comisión del hecho punible, así como los exámenes médicos psicofísicos pertinentes a la mujer víctima de violencia.

Remisión al Ministerio Público
Artículo 98. - Dictadas las medidas de protección y seguridad, así como practicadas todas las diligencias necesarias y urgentes, las cuales no podrán exceder de quince

días continuos, el órgano receptor deberá remitir las actuaciones al Ministerio Público, para que continúe la investigación.

Violación de derechos y garantías constitucionales
Artículo 99. - Cuando una de las partes no estuviere conforme con la medida dictada por el órgano receptor, podrá solicitar ante el Tribunal de Violencia contra la Mujer en funciones de Control, Audiencia y Medidas, su revisión, el cual requerirá las actuaciones al Ministerio Público o al órgano receptor correspondiente, si fuera el caso.

Si recibidas por el o la Fiscal del Ministerio Público, las actuaciones procedentes de otro órgano receptor, éste observare violación de derechos y garantías constitucionales, procederá de inmediato a solicitar motivadamente su revisión ante el juez o jueza de Control, Audiencia y Medidas; para ello remitirá las actuaciones originales, dejando en el Despacho Fiscal copia simple de las mismas para continuar con la investigación.

Revisión y decisión de las medidas
Artículo 100. - Dentro de los tres días de despacho siguientes a la recepción de las actuaciones, el juez o jueza de Control, Audiencia y Medidas revisará las medidas, y mediante auto motivado se pronunciará modificando, sustituyendo, confirmando o revocando las mismas.

Remisión de las actuaciones
Artículo 101. - Al siguiente día de publicada la decisión a que se refiere el artículo anterior, el Tribunal de Control, Audiencia y Medidas remitirá las actuaciones originales al Ministerio Público o al órgano receptor correspondiente si fuera el caso, para que continúe con el procedimiento.

Fin de la investigación
Artículo 102. - Concluida la investigación, conforme a lo previsto en el artículo 79 o el supuesto especial previsto en el artículo 103 de esta Ley, el Ministerio Público procederá a dictar el acto conclusivo correspondiente.

Prórroga extraordinaria por omisión fiscal
Artículo 103. - Si vencidos todos los plazos, el o la Fiscal del Ministerio Público no dictare el acto conclusivo correspondiente, el juez o la jueza de Control, Audiencia y Medidas notificará dicha omisión a el o la Fiscal Superior, quien dentro de los dos días siguientes deberá comisionar un nuevo o una nueva Fiscal para que presente las conclusiones de la investigación en un lapso que no excederá de diez días continuos contados a partir de la notificación de la comisión, sin perjuicio de las sanciones civiles, penales y administrativas que sean aplicables a el o a la Fiscal omisivo u omisiva.

Transcurrida la prórroga extraordinaria a que se refiere el presente artículo, sin actuación por parte del Ministerio Público, el Tribunal de Control, Audiencia y Medidas decretará el archivo judicial, conforme a lo dispuesto en el Código Orgánico Procesal Penal.

De la audiencia preliminar
Artículo 104. - Presentada la acusación ante el Tribunal de Violencia Contra la Mujer en Funciones de Control, Audiencia y Medidas, éste fijará la audiencia para oír a las partes, dentro de los diez días hábiles siguientes.

Antes del vencimiento de dicho plazo, las partes procederán a ofrecer las pruebas que serán evacuadas en la audiencia de juicio oral y oponer las excepciones que estimen procedentes. El tribunal se pronunciará en la audiencia.

En este acto el imputado podrá admitir los hechos, pero la pena a imponerse sólo podrá rebajarse en un tercio.

Finalizada la audiencia, el juez o la jueza expondrá fundadamente su decisión respecto a los planteamientos de las partes. En caso de admitir la acusación, dictará el auto de apertura a juicio y remitirá las actuaciones al tribunal de juicio que corresponda.

El auto de apertura a juicio será inapelable.

Sección Séptima: Del Juicio Oral

Del juicio oral
Artículo 105. - Recibidas las actuaciones, el Tribunal de Juicio fijará la fecha para la celebración de la audiencia oral y pública, en un plazo que no podrá ser menor de diez días hábiles ni mayor de veinte.

De la audiencia de juicio oral
Artículo 106. - En la Audiencia de Juicio actuará sólo un juez o jueza profesional. El debate será oral y público, pudiendo el juez o jueza decidir efectuarlo, total o parcialmente a puerta cerrada, previa solicitud de la víctima. El juez o la jueza deberá informar a la víctima de este derecho antes del inicio del acto. La audiencia se desarrollará en un solo día; si no fuere posible, continuará en el menor número de días hábiles consecutivos. Se podrá suspender por un plazo máximo de cinco días, sólo en los casos siguientes:
1. Por causa de fuerza mayor.
2. Por falta de intérprete.
3. Cuando el defensor o la defensora o el Ministerio Público lo soliciten en razón de la ampliación de la acusación.
4. Para resolver cuestiones incidentales o la práctica de algún acto fuera de la sala de audiencia.
5. Cualquier otro motivo que sea considerado relevante por el tribunal.

De la decisión
Artículo 107. - Finalizado el debate se levantará acta de todo lo acontecido, la cual será leída a viva voz y firmada por los o las intervinientes.

El juez o la jueza pasará a sentenciar en la sala destinada a tal efecto, a la cual no tendrán acceso en ningún momento las partes. La sentencia será dictada el mismo día, procediéndose a su lectura y quedando así notificadas las partes.

El documento original se archivará. Las partes podrán solicitar copia de la sentencia.

En caso que no sea posible la redacción de la sentencia en el mismo día, el juez o la jueza expondrá a las partes los fundamentos de la misma y leerá la parte dispositiva.

La publicación se realizará dentro de los cinco días hábiles siguientes al pronunciamiento de la dispositiva.

Del recurso de apelación
Artículo 108. - Contra la sentencia dictada en la audiencia oral se interpondrá recurso de apelación ante el tribunal que la dictó y podrá ser ejercido dentro de los tres días hábiles siguientes a la fecha de la publicación del texto íntegro del fallo.

Formalidades
Artículo 109. - El recurso sólo podrá fundarse en:
1. Violación de normas relativas a la oralidad, inmediación y concentración del juicio.
2. Falta, contradicción o ilogicidad manifiesta en la motivación de la sentencia, o cuando ésta se funde en prueba obtenida ilegalmente o incorporada con violación a los principios de la audiencia oral.
3. Quebrantamiento u omisión de formas sustanciales de los actos que causen indefensión.
4. Incurrir en violación de la ley por inobservancia o errónea aplicación de una norma jurídica.

Contestación del recurso
Artículo 110. - Presentado el recurso, las otras partes lo contestarán dentro de los tres días hábiles siguientes al vencimiento del lapso para su interposición. Al vencimiento de este plazo, el tribunal remitirá las actuaciones a la Corte de Apelaciones para que ésta decida.

De la Corte de Apelaciones
Artículo 111. - Recibidas las actuaciones, la Corte de Apelaciones tendrá un lapso de tres días hábiles siguientes a la fecha de su recibo para decidir sobre la admisibilidad del recurso. Admitido éste, fijará una audiencia oral que debe realizarse dentro de un plazo no menor de tres días hábiles ni mayor de cinco, contados a partir de la fecha de la admisión. El auto de apertura a juicio será inapelable.

De la audiencia
Artículo 112. - En la audiencia los jueces o las juezas podrán interrogar a las partes; resolverán motivadamente con las pruebas que se promuevan y sean útiles y pertinentes. Al concluir la audiencia deberán dictar el pronunciamiento correspondiente. Cuando la complejidad del caso lo amerite, podrán decidir dentro de los cinco días hábiles siguientes.

Casación
Artículo 113. - El ejercicio del Recurso de Casación se regirá por lo dispuesto en el Código Orgánico Procesal Penal.

Sección Octava: De los Órganos Jurisdiccionales y del Ministerio Público

Atribuciones de los y las Fiscales del Ministerio Público
Artículo 114. - Son atribuciones de los y las Fiscales del Ministerio Público especializados en violencia contra las mujeres:
1. Ejercer la acción penal correspondiente.
2. Velar por el cumplimiento de las disposiciones previstas en esta Ley.
3. Investigar los hechos que se tipifican como delitos en esta Ley.
4. Solicitar y aportar pruebas y participar en su producción.
5. Dirigir y supervisar el cumplimiento de las funciones de la Policía de Investigación.
6. Solicitar fundadamente al órgano jurisdiccional las medidas cautelares pertinentes.
7. Solicitar al órgano jurisdiccional la sustitución, modificación, confirmación o revocación de las medidas de protección dictadas por los órganos receptores o de las medidas cautelares que hubiere dictado.
8. Solicitar fundadamente al órgano jurisdiccional el decomiso definitivo del arma incautada por el órgano receptor. En los casos en que resultare procedente, solicitará también la prohibición del porte de armas.
9. Reunir los elementos de convicción conducentes a la elaboración del acto conclusivo, en cuyos trámites se observarán las normas dispuestas en el Código Orgánico Procesal Penal.
10. Cualquier otra actuación prevista en el ordenamiento jurídico.

Jurisdicción
Artículo 115. - Corresponde a los tribunales de violencia contra la mujer y a la Sala de Casación Penal del Tribunal Supremo de Justicia, el ejercicio de la jurisdicción para la resolución de los asuntos sometidos a su decisión, conforme a lo establecido en esta Ley, las leyes de organización judicial y la reglamentación interna.

Creación de los tribunales de violencia contra la mujer
Artículo 116. - Se crean los tribunales de violencia contra la mujer que tendrán su sede en Caracas y en cada capital de estado, además de las localidades que determine el Tribunal Supremo de Justicia a través de la Dirección Ejecutiva de la Magistratura.

Constitución de los tribunales de violencia contra la mujer
Artículo 117. - Los tribunales de violencia contra la mujer se organizarán en circuitos judiciales, de acuerdo con lo que determine la Dirección Ejecutiva de la Magistratura, la cual podrá crear más de un circuito judicial en una misma circunscripción, cuando por razones de servicio sea necesario. Su organización

y funcionamiento se regirán por las disposiciones establecidas en esta Ley, en las leyes orgánicas correspondientes y en el Reglamento Interno de los Circuitos Judiciales.

En cada circuito judicial los tribunales de violencia contra la mujer estarán constituidos en primera instancia por jueces y juezas de control, audiencia y medidas; jueces y juezas de juicio y jueces y juezas de ejecución. En segunda instancia lo conforman las Cortes de Apelaciones.

Competencia
Artículo 118. - Los tribunales de violencia contra la mujer conocerán en el orden penal de los delitos previstos en esta Ley, así como del delito de lesiones en todas sus calificaciones tipificadas en el Código Penal en los supuestos establecidos en el artículo 42 de la presente Ley y conforme al procedimiento especial aquí establecido.

En el orden civil, conocerán de todos aquellos asuntos de naturaleza patrimonial.

Casación
Artículo 119. - La Sala de Casación Penal del Tribunal Supremo de Justicia conocerá del Recurso de Casación.

Sección Novena: De los Servicios Auxiliares

Servicios auxiliares
Artículo 120. - Los tribunales de violencia contra la mujer contarán con:
1. Equipos multidisciplinarios o la asignación presupuestaria para la contratación de los mismos.
2. Una sala de trabajo para el equipo multidisciplinario.
3. Una sala de citaciones y notificaciones.

Objetivos del equipo interdisciplinario
Artículo 121. - Cada Tribunal de Violencia Contra la Mujer debe contar con un equipo multidisciplinario que se organizará como servicio auxiliar de carácter independiente e imparcial, para brindar al ejercicio de la función jurisdiccional experticia bio-psicosocial-legal de forma colegiada e interdisciplinaria. Este equipo estará integrado por profesionales de la medicina, de la psiquiatría, de la educación, de la psicología, de trabajo social, de derecho, de criminología y de otras profesiones con experticia en la materia. En las zonas en que sea necesario, se contará con expertos o expertas interculturales bilingües en idiomas indígenas.

Atribuciones del equipo interdisciplinario
Artículo 122. - Son atribuciones de los equipos interdisciplinarios de los tribunales de violencia contra la mujer:
1. Emitir opinión, mediante informes técnicos integrales sobre la procedencia de proteger a la mujer víctima de violencia, a través de medidas cautelares específicas.
2. Intervenir como expertos independientes e imparciales del Sistema de Justicia

en los procedimientos judiciales, realizando experticias mediante informes técnicos integrales.
3. Brindar asesoría integral a las personas a quienes se dicten medidas cautelares.
4. Asesorar al juez o a la jueza en la obtención y estimación de la opinión o testimonio de los niños, niñas y adolescentes, según su edad y grado de madurez.
5. Auxiliar a los tribunales de violencia contra la mujer en la ejecución de las decisiones judiciales.
6. Las demás que establezca la ley.

Dotación
Artículo 123. - Los tribunales de violencia contra la mujer deben ser dotados de las instalaciones, equipo y personal necesario para el cumplimiento de sus funciones; entre otras áreas, deben contar con:
1. Un espacio dirigido especialmente a la atención de la mujer agredida, separado del destinado a la persona agresora.
2. Un espacio y dotación apropiada para la realización de las funciones del equipo interdisciplinario.

Parágrafo Único: El ministerio con competencia en materia del interior y justicia creará en el Cuerpo de Investigaciones Científicas, Penales y Criminalísticas, una unidad médicoforense conformada por expertos para la atención de los casos de mujeres víctimas de violencia que emitirán los informes y experticias correspondientes en forma oportuna y expedita.

DISPOSICIONES TRANSITORIAS
Primera. - Hasta tanto sean creados los tribunales especializados en materia de violencia contra la mujer, el Tribunal Supremo de Justicia proveerá lo conducente para que las funciones de éstos sean cumplidas por los tribunales penales en funciones de control, juicio y ejecución ordinarios a los cuales se les conferirá competencia exclusiva en materia de violencia contra las mujeres por vía de resolución de la Dirección Ejecutiva de la Magistratura, para el momento de entrada en vigencia de esta Ley.

El Tribunal Supremo de Justicia, diligenciará lo necesario para que la creación de los tribunales especializados en violencia contra la mujer, se ejecute dentro de un año contado a partir de la vigencia de la presente Ley. En dicho lapso se procederá a capacitar a los jueces y juezas, así como a los funcionarios y funcionarias que hayan de intervenir como operadores u operadoras de justicia en materia de violencia contra la mujer, por profesionales adscritos o adscritas al Instituto Nacional de la Mujer, Defensoría del Pueblo, Defensoría Nacional de los Derechos de la Mujer, universidades, organizaciones no gubernamentales, organismos internacionales, y cualquier otro ente especializado en justicia de género.

Segunda. - Hasta tanto sean creadas las unidades de atención y tratamiento de hechos de violencia contra la mujer, los jueces y las juezas para sentenciar podrán considerar los informes emanados de cualquier organismo público o privado de salud.

Los estados y municipios proveerán lo conducente para crear y poner en funcionamiento las unidades de atención y tratamiento, dentro del año siguiente a la entrada en vigencia de la presente Ley. En dicho lapso procederán a capacitar a las funcionarias y funcionarios que conformarán los mismos. Los informes y recomendaciones emanados de las expertas y los expertos de las organizaciones no gubernamentales, especializadas en la atención de los hechos de violencia contemplados en esta Ley, podrán ser igualmente considerados por los jueces y juezas.

Tercera. - Hasta tanto sean creados los lugares de cumplimiento de la sanción de los responsables por hechos de violencia contra las mujeres, el ministerio con competencia en la materia tomará las previsiones para adecuar los sitios de reclusión y facilitar la reeducación de los agresores.

La creación de dichos centros deberá desarrollarse en un plazo máximo de un año, luego de la entrada en vigencia de esta Ley. En dicho lapso se procederá a capacitar a los funcionarios, funcionarias y todas aquellas personas que intervendrán en el tratamiento de los penados por los delitos previstos en esta Ley.

Cuarta. - En un lapso no mayor de un año, contado a partir de la publicación de esta Ley, la Nación, los estados y municipios deben disponer lo conducente para la creación y adaptación de las unidades, entidades y órganos aquí previstos. En el mismo lapso debe dictarse la normativa necesaria a los efectos de ejecutar sus disposiciones.

Quinta. - De conformidad con el artículo 24 de la Constitución de la República Bolivariana de Venezuela, las disposiciones procesales previstas en esta Ley se aplicarán desde el mismo momento de entrar en vigencia, aun a los procesos que se hallaren en curso, sin menoscabo del principio de irretroactividad en cuanto favorezcan al imputado o a la imputada, al acusado o a la acusada, al penado o penada.

Los recursos ya interpuestos, la evacuación de las pruebas ya admitidas, así como los términos o lapsos que hayan comenzado a correr, se regirán por las disposiciones anteriores.

El Ministerio Público proveerá lo conducente para que las causas que se encuentren en fase de investigación sean tramitadas en forma expedita y presentado el acto conclusivo correspondiente dentro de los seis meses siguientes a la vigencia de la presente Ley.

Sexta. - El Ejecutivo Nacional incluirá en las leyes de presupuesto anuales, a partir del año inmediatamente siguiente a la sanción de esta Ley, los recursos necesarios para el funcionamiento de los órganos, entidades y programas aquí previstos.

Séptima. - Las publicaciones oficiales y privadas de la presente Ley deberán ir precedidas de su exposición de motivos.

DISPOSICIÓN DEROGATORIA
Única. - Se deroga la Ley Sobre la Violencia contra la Mujer y la Familia de fecha tres de septiembre de 1998, publicada en la Gaceta Oficial de la República de Venezuela Nº 36.531, así como las disposiciones contrarias a la presente Ley.

Mexico[1]

LEY GENERAL DE ACCESO DE LAS MUJERES A UNA VIDA LIBRE DE VIOLENCIA

Nueva Ley publicada en el Diario Oficial de la Federación el 1o de febrero de 2007

TEXTO VIGENTE
Última reforma publicada DOF 20-01-2009
Al margen un sello con el Escudo Nacional, que dice: Estados Unidos Mexicanos. - Presidencia de la República.
FELIPE DE JESÚS CALDERÓN HINOJOSA, Presidente de los Estados Unidos Mexicanos, a sus habitantes sabed:
Que el Honorable Congreso de la Unión, se ha servido dirigirme el siguiente
DECRETO
"EL CONGRESO GENERAL DE LOS ESTADOS UNIDOS MEXICANOS, DECRETA:
SE EXPIDE LA LEY GENERAL DE ACCESO DE LAS MUJERES A UNA VIDA LIBRE DE VIOLENCIA.
Artículo Único. - Se expide la Ley General de Acceso de las Mujeres a una Vida Libre de Violencia. LEY GENERAL DE ACCESO DE LAS MUJERES A UNA VIDA LIBRE DE VIOLENCIA. TITULO PRIMERO

CAPÍTULO I
DISPOSICIONES GENERALES

ARTÍCULO 1. La presente ley tiene por objeto establecer la coordinación entre la Federación, las entidades federativas, el Distrito Federal y los municipios para prevenir, sancionar y erradicar la violencia contra las mujeres, así como los principios y modalidades para garantizar su acceso a una vida libre de violencia que favorezca su desarrollo y bienestar conforme a los principios de igualdad y de no discriminación, así como para garantizar la democracia, el desarrollo integral y sustentable que fortalezca la soberanía y el régimen democrático establecidos en la Constitución Política de los Estados Unidos Mexicanos.
Las disposiciones de esta ley son de orden público, interés social y de observancia general en la República Mexicana.

1. At States level, ob-gyn violence is classified as a crime in: Chiapas, Estado de México, Guerrero, Quintana Roo, and Veracruz.

ARTÍCULO 2. La Federación, las entidades federativas, el Distrito Federal y los municipios, en el ámbito de sus respectivas competencias expedirán las normas legales y tomarán las medidas presupuestales y administrativas correspondientes, para garantizar el derecho de las mujeres a una vida libre de violencia, de conformidad con los Tratados Internacionales en Materia de Derechos Humanos de las Mujeres, ratificados por el Estado mexicano.

ARTÍCULO 3. - Todas las medidas que se deriven de la presente ley, garantizarán la prevención, la atención, la sanción y la erradicación de todos los tipos de violencia contra las mujeres durante su ciclo de vida y para promover su desarrollo integral y su plena participación en todas las esferas de la vida.

ARTÍCULO 4. - Los principios rectores para el acceso de todas las mujeres a una vida libre de violencia que deberán ser observados en la elaboración y ejecución de las políticas públicas federales y locales son:
I. La igualdad jurídica entre la mujer y el hombre;
II. El respeto a la dignidad humana de las mujeres;
III. La no discriminación, y
IV. La libertad de las mujeres.

ARTÍCULO 5. - Para los efectos de la presente ley se entenderá por:
I. Ley: La Ley General de Acceso de las Mujeres a una Vida Libre de Violencia;
II. Programa: El Programa Integral para Prevenir, Atender, Sancionar y Erradicar la Violencia contra las Mujeres;
III. Sistema: El Sistema Nacional de Prevención, Atención, Sanción y Erradicación de la Violencia contra las Mujeres;
IV. Violencia contra las Mujeres: Cualquier acción u omisión, basada en su género, que les cause daño o sufrimiento psicológico, físico, patrimonial, económico, sexual o la muerte tanto en el ámbito privado como en el público;
V. Modalidades de Violencia: Las formas, manifestaciones o los ámbitos de ocurrencia en que se presenta la violencia contra las mujeres;
VI. Víctima: La mujer de cualquier edad a quien se le inflige cualquier tipo de violencia;
VII. Agresor: La persona que inflige cualquier tipo de violencia contra las mujeres;
VIII. Derechos Humanos de las Mujeres: Refiere a los derechos que son parte inalienable, integrante e indivisible de los derechos humanos universales contenidos en la Convención sobre la Eliminación de Todos las Formas de Discriminación contra la Mujer (CEDAW), la Convención sobre los Derechos de la Niñez, la Convención Interamericana para Prevenir, Sancionar y Erradicar la Violencia contra la Mujer (Belem Do Pará) y demás instrumentos internacionales en la materia;
IX. Perspectiva de Género: Es una visión científica, analítica y política sobre las mujeres y los hombres. Se propone eliminar las causas de la opresión de género como la desigualdad, la injusticia y la jerarquización de las personas basada en el género. Promueve la igualdad entre los géneros a través de la equidad, el adelanto y el bienestar de las mujeres; contribuye a construir una sociedad en

donde las mujeres y los hombres tengan el mismo valor, la igualdad de derechos y oportunidades para acceder a los recursos económicos y a la representación política y social en los ámbitos de toma de decisiones;
X. Empoderamiento de las Mujeres: Es un proceso por medio del cual las mujeres transitan de cualquier situación de opresión, desigualdad, discriminación, explotación o exclusión a un estadio de
conciencia, autodeterminación y autonomía, el cual se manifiesta en el ejercicio del poder democrático que emana del goce pleno de sus derechos y libertades, y
XI. Misoginia: Son conductas de odio hacia la mujer y se manifiesta en actos violentos y crueles contra ella por el hecho de ser mujer.

ARTÍCULO 6. Los tipos de violencia contra las mujeres son:
I. La violencia psicológica. Es cualquier acto u omisión que dañe la estabilidad psicológica, que puede consistir en: negligencia, abandono, descuido reiterado, celotipia, insultos, humillaciones, devaluación, marginación, indiferencia, infidelidad, comparaciones destructivas, rechazo, restricción a la autodeterminación y amenazas, las cuales conllevan a la víctima a la depresión, al aislamiento, a la devaluación de su autoestima e incluso al suicidio;
II. La violencia física. - Es cualquier acto que inflige daño no accidental, usando la fuerza física o algún tipo de arma u objeto que pueda provocar o no lesiones ya sean internas, externas, o ambas;
III. La violencia patrimonial. - Es cualquier acto u omisión que afecta la supervivencia de la víctima. Se manifiesta en: la transformación, sustracción, destrucción, retención o distracción de objetos, documentos personales, bienes y valores, derechos patrimoniales o recursos económicos destinados a satisfacer sus necesidades y puede abarcar los daños a los bienes comunes o propios de la víctima;
IV. Violencia económica. - Es toda acción u omisión del Agresor que afecta la supervivencia económica de la víctima. Se manifiesta a través de limitaciones encaminadas a controlar el ingreso de sus percepciones económicas, así como la percepción de un salario menor por igual trabajo, dentro de un mismo centro laboral;
V. La violencia sexual. - Es cualquier acto que degrada o daña el cuerpo y/o la sexualidad de la Víctima y que por tanto atenta contra su libertad, dignidad e integridad física. Es una expresión de abuso de poder que implica la supremacía masculina sobre la mujer, al denigrarla y concebirla como objeto, y
VI. Cualesquiera otras formas análogas que lesionen o sean susceptibles de dañar la dignidad, integridad o libertad de las mujeres.

TITULO II MODALIDADES DE LA VIOLENCIA
CAPÍTULO I
DE LA VIOLENCIA EN EL ÁMBITO FAMILIAR

ARTÍCULO 7. - Violencia familiar: Es el acto abusivo de poder u omisión intencional, dirigido a dominar, someter, controlar, o agredir de manera física, verbal, psicológica, patrimonial, económica y sexual a las mujeres, dentro o fuera

del domicilio familiar, cuyo Agresor tenga o haya tenido relación de parentesco por consanguinidad o afinidad, de matrimonio, concubinato o mantengan o hayan mantenido una relación de hecho.

ARTÍCULO 8. - Los modelos de atención, prevención y sanción que establezcan la Federación, las entidades federativas, el Distrito Federal y los municipios, son el conjunto de medidas y acciones para proteger a las víctimas de violencia familiar, como parte de la obligación del Estado, de garantizar a las mujeres su seguridad y el ejercicio pleno de sus derechos humanos. Para ello, deberán tomar en consideración:
I. Proporcionar atención, asesoría jurídica y tratamiento psicológico especializados y gratuitos a las víctimas, que favorezcan su empoderamiento y reparen el daño causado por dicha violencia;
II. Brindar servicios reeducativos integrales, especializados y gratuitos al Agresor para erradicar las conductas violentas a través de una educación que elimine los estereotipos de supremacía masculina, y los patrones machistas que generaron su violencia;
III. Evitar que la atención que reciban la Víctima y el Agresor sea proporcionada por la misma persona y en el mismo lugar. En ningún caso podrán brindar atención, aquellas personas que hayan sido sancionadas por ejercer algún tipo de violencia;
IV. Evitar procedimientos de mediación o conciliación, por ser inviables en una relación de sometimiento entre el Agresor y la Víctima;
V. Favorecer la separación y alejamiento del Agresor con respecto a la Víctima, y
VI. Favorecer la instalación y el mantenimiento de refugios para las víctimas y sus hijas e hijos; la información sobre su ubicación será secreta y proporcionarán apoyo psicológico y legal especializados y gratuitos. Las personas que laboren en los refugios deberán contar con la cédula profesional correspondiente a la especialidad en que desarrollen su trabajo. En ningún caso podrán laborar en los refugios personas que hayan sido sancionadas por ejercer algún tipo violencia.

ARTÍCULO 9. - Con el objeto de contribuir a la erradicación de la violencia contra las mujeres dentro de la familia, los Poderes Legislativos, Federal y Locales, en el respectivo ámbito de sus competencias, considerarán:
I. Tipificar el delito de violencia familiar, que incluya como elementos del tipo los contenidos en la definición prevista en el artículo 7 de esta ley;
II. Establecer la violencia familiar como causal de divorcio, de pérdida de la patria potestad y de restricción para el régimen de visitas, así como impedimento para la guarda y custodia de niñas y niños;
III. Disponer que cuando la pérdida de la patria potestad sea por causa de violencia familiar y/o incumplimiento de obligaciones alimentarias o de crianza, no podrá recuperarse la misma, y
IV. Incluir como parte de la sentencia, la condena al Agresor a participar en servicios reeducativos integrales, especializados y gratuitos.

CAPÍTULO II
DE LA VIOLENCIA LABORAL Y DOCENTE

ARTÍCULO 10. - Violencia Laboral y Docente: Se ejerce por las personas que tienen un vínculo laboral, docente o análogo con la víctima, independientemente de la relación jerárquica, consistente en un acto o una omisión en abuso de poder que daña la autoestima, salud, integridad, libertad y seguridad de la víctima, e impide su desarrollo y atenta contra la igualdad.
Puede consistir en un solo evento dañino o en una serie de eventos cuya suma produce el daño. También incluye el acoso o el hostigamiento sexual.

ARTÍCULO 11. - Constituye violencia laboral: la negativa ilegal a contratar a la Víctima o a respetar su permanencia o condiciones generales de trabajo; la descalificación del trabajo realizado, las amenazas, la intimidación, las humillaciones, la explotación y todo tipo de discriminación por condición de género.

ARTÍCULO 12. - Constituyen violencia docente: aquellas conductas que dañen la autoestima de las alumnas con actos de discriminación por su sexo, edad, condición social, académica, limitaciones y/o características físicas, que les infligen maestras o maestros.

ARTÍCULO 13. - El hostigamiento sexual es el ejercicio del poder, en una relación de subordinación real de la víctima frente al agresor en los ámbitos laboral y/o escolar. Se expresa en conductas verbales, físicas o ambas, relacionadas con la sexualidad de connotación lasciva.
El acoso sexual es una forma de violencia en la que, si bien no existe la subordinación, hay un ejercicio abusivo de poder que conlleva a un estado de indefensión y de riesgo para la víctima, independientemente de que se realice en uno o varios eventos.

ARTÍCULO 14. - Las entidades federativas y el Distrito Federal, en función de sus atribuciones, tomarán en consideración:
I. Establecer las políticas públicas que garanticen el derecho de las mujeres a una vida libre de violencia en sus relaciones laborales y/o de docencia;
II. Fortalecer el marco penal y civil para asegurar la sanción a quienes hostigan y acosan;
III. Promover y difundir en la sociedad que el hostigamiento sexual y el acoso sexual son delitos, y
IV. Diseñar programas que brinden servicios reeducativos integrales para víctimas y agresores.

ARTÍCULO 15. - Para efectos del hostigamiento o el acoso sexual, los tres órdenes de gobierno deberán:
I. Reivindicar la dignidad de las mujeres en todos los ámbitos de la vida;
II. Establecer mecanismos que favorezcan su erradicación en escuelas y centros

laborales privados o públicos, mediante acuerdos y convenios con instituciones escolares, empresas y sindicatos;
III. Crear procedimientos administrativos claros y precisos en las escuelas y los centros laborales, para sancionar estos ilícitos e inhibir su comisión.
IV. En ningún caso se hará público el nombre de la víctima para evitar algún tipo de sobrevictimización o que sea boletinada o presionada para abandonar la escuela o trabajo;
V. Para los efectos de la fracción anterior, deberán sumarse las quejas anteriores que sean sobre el mismo hostigador o acosador, guardando públicamente el anonimato de la o las quejosas;
VI. Proporcionar atención psicológica y legal, especializada y gratuita a quien sea víctima de hostigamiento o acoso sexual, y
VII. Implementar sanciones administrativas para los superiores jerárquicos del hostigador o acosador cuando sean omisos en recibir y/o dar curso a una queja.

CAPÍTULO III
DE LA VIOLENCIA EN LA COMUNIDAD

ARTÍCULO 16. - Violencia en la Comunidad: Son los actos individuales o colectivos que transgreden derechos fundamentales de las mujeres y propician su denigración, discriminación, marginación o exclusión en el ámbito público.
ARTÍCULO 17. - El Estado mexicano debe garantizar a las mujeres la erradicación de la violencia en la comunidad, a través de:
I. La reeducación libre de estereotipos y la información de alerta sobre el estado de riesgo que enfrentan las mujeres en una sociedad desigual y discriminatoria;
II. El diseño de un sistema de monitoreo del comportamiento violento de los individuos y de la sociedad contra las mujeres, y
III. El establecimiento de un banco de datos sobre las órdenes de protección y de las personas sujetas a ellas, para realizar las acciones de política criminal que correspondan y faciliten el intercambio de información entre las instancias.

CAPÍTULO IV
DE LA VIOLENCIA INSTITUCIONAL

ARTÍCULO 18. - Violencia Institucional: Son los actos u omisiones de las y los servidores públicos de cualquier orden de gobierno que discriminen o tengan como fin dilatar, obstaculizar o impedir el goce y ejercicio de los derechos humanos de las mujeres así como su acceso al disfrute de políticas públicas destinadas a prevenir, atender, investigar, sancionar y erradicar los diferentes tipos de violencia.

ARTÍCULO 19. - Los tres órdenes de gobierno, a través de los cuales se manifiesta el ejercicio del poder público, tienen la obligación de organizar el aparato gubernamental de manera tal que sean capaces de asegurar, en el ejercicio de sus funciones, el derecho de las mujeres a una vida libre de violencia.

ARTÍCULO 20. - Para cumplir con su obligación de garantizar el derecho de las mujeres a una vida libre de violencia, los tres órdenes de gobierno deben prevenir, atender, investigar, sancionar y reparar el daño que les inflige.

CAPÍTULO V
DE LA VIOLENCIA FEMINICIDA Y DE LA ALERTA DE VIOLENCIA DE GÉNERO CONTRA LAS MUJERES

ARTÍCULO 21. - Violencia Feminicida: Es la forma extrema de violencia de género contra las mujeres, producto de la violación de sus derechos humanos, en los ámbitos público y privado, conformada por el conjunto de conductas misóginas que pueden conllevar impunidad social y del Estado y puede culminar en homicidio y otras formas de muerte violenta de mujeres.

ARTÍCULO 22. - Alerta de violencia de género: Es el conjunto de acciones gubernamentales de emergencia para enfrentar y erradicar la violencia feminicida en un territorio determinado, ya sea ejercida por individuos o por la propia comunidad.

ARTÍCULO 23. - La alerta de violencia de género contra las mujeres tendrá como objetivo fundamental garantizar la seguridad de las mismas, el cese de la violencia en su contra y eliminar las desigualdades producidas por una legislación que agravia sus derechos humanos, por lo que se deberá:
I. Establecer un grupo interinstitucional y multidisciplinario con perspectiva de género que dé el seguimiento respectivo;
II. Implementar las acciones preventivas, de seguridad y justicia, para enfrentar y abatir la violencia feminicida;
III. Elaborar reportes especiales sobre la zona y el comportamiento de los indicadores de la violencia contra las mujeres;
IV. Asignar los recursos presupuestales necesarios para hacer frente a la contingencia de alerta de violencia de género contra las mujeres, y
V. Hacer del conocimiento público el motivo de la alerta de violencia de género contra las mujeres, y la zona territorial que abarcan las medidas a implementar.

ARTÍCULO 24. - La declaratoria de alerta de violencia de género contra las mujeres, se emitirá cuando:
I. Los delitos del orden común contra la vida, la libertad, la integridad y la seguridad de las mujeres, perturben la paz social en un territorio determinado y la sociedad así lo reclame;
II. Exista un agravio comparado que impida el ejercicio pleno de los derechos humanos de las mujeres, y
III. Los organismos de derechos humanos a nivel nacional o de las entidades federativas, los organismos de la sociedad civil y/o los organismos internacionales, así lo soliciten.

ARTÍCULO 25. - Corresponderá al gobierno federal a través de la Secretaría de Gobernación declarar la alerta de violencia de género y notificará la declaratoria al Poder Ejecutivo de la entidad federativa de que se trate.

ARTÍCULO 26. - Ante la violencia feminicida, el Estado mexicano deberá resarcir el daño conforme a los parámetros establecidos en el Derecho Internacional de los Derechos Humanos y considerar como reparación:
I. El derecho a la justicia pronta, expedita e imparcial: Se deben investigar las violaciones a los derechos de las mujeres y sancionar a los responsables;
II. La rehabilitación: Se debe garantizar la prestación de servicios jurídicos, médicos y psicológicos especializados y gratuitos para la recuperación de las víctimas directas o indirectas;
III. La satisfacción: Son las medidas que buscan una reparación orientada a la prevención de violaciones. Entre las medidas a adoptar se encuentran:
a) La aceptación del Estado de su responsabilidad ante el daño causado y su compromiso de repararlo;
b) La investigación y sanción de los actos de autoridades omisas o negligentes que llevaron la violación de los derechos humanos de las Víctimas a la impunidad;
c) El diseño e instrumentación de políticas públicas que eviten la comisión de delitos contra las mujeres, y
d) La verificación de los hechos y la publicidad de la verdad.

CAPÍTULO VI
DE LAS ÓRDENES DE PROTECCIÓN

ARTÍCULO 27. - Las órdenes de protección: Son actos de protección y de urgente aplicación en función del interés superior de la Víctima y son fundamentalmente precautorias y cautelares. Deberán otorgarse por la autoridad competente, inmediatamente que conozcan de hechos probablemente constitutivos de infracciones o delitos que impliquen violencia contra las mujeres.

ARTÍCULO 28. - Las órdenes de protección que consagra la presente ley son personalísimas e intransferibles y podrán ser:
I. De emergencia;
II. Preventivas, y
III. De naturaleza Civil.
Las órdenes de protección de emergencia y preventivas tendrán una temporalidad no mayor de 72 horas y deberán expedirse dentro de las 24 horas siguientes al conocimiento de los hechos que las generan.

ARTÍCULO 29. - Son órdenes de protección de emergencia las siguientes:
I. Desocupación por el agresor, del domicilio conyugal o donde habite la víctima, independientemente
de la acreditación de propiedad o posesión del inmueble, aún en los casos de arrendamiento del mismo;
II. Prohibición al probable responsable de acercarse al domicilio, lugar de trabajo, de estudios, del domicilio de las y los ascendientes y descendientes o cualquier otro que frecuente la víctima;
III. Reingreso de la víctima al domicilio, una vez que se salvaguarde de su seguridad, y
IV. Prohibición de intimidar o molestar a la víctima en su entorno social, así como a cualquier integrante de su familia.

ARTÍCULO 30. - Son órdenes de protección preventivas las siguientes:
I. Retención y guarda de armas de fuego propiedad del Agresor o de alguna institución privada de seguridad, independientemente si las mismas se encuentran registradas conforme a la normatividad de la materia.
Es aplicable lo anterior a las armas punzocortantes y punzocontundentes que independientemente de su uso, hayan sido empleadas para amenazar o lesionar a la víctima;
II. Inventario de los bienes muebles e inmuebles de propiedad común, incluyendo los implementos de trabajo de la víctima;
III. Uso y goce de bienes muebles que se encuentren en el inmueble que sirva de domicilio de la víctima;
IV. Acceso al domicilio en común, de autoridades policíacas o de personas que auxilien a la Víctima a tomar sus pertenencias personales y las de sus hijas e hijos;
V. Entrega inmediata de objetos de uso personal y documentos de identidad de la víctima y de sus hijas e hijos;
VI. Auxilio policíaco de reacción inmediata a favor de la víctima, con autorización expresa de ingreso al domicilio donde se localice o se encuentre la Víctima en el momento de solicitar el auxilio, y
VII. Brindar servicios reeducativos integrales especializados y gratuitos, con perspectiva de género al agresor en instituciones públicas debidamente acreditadas.

ARTÍCULO 31. - Corresponderá a las autoridades federales, estatales y del Distrito Federal, en el ámbito de sus competencias, otorgar las órdenes emergentes y preventivas de la presente ley, quienes tomarán en consideración:
I. El riesgo o peligro existente;
II. La seguridad de la víctima, y
III. Los elementos con que se cuente.

ARTÍCULO 32. - Son órdenes de protección de naturaleza civil las siguientes:
I. Suspensión temporal al agresor del régimen de visitas y convivencia con sus descendientes;
II. Prohibición al agresor de enajenar o hipotecar bienes de su propiedad cuando se trate del domicilio conyugal; y en cualquier caso cuando se trate de bienes de la sociedad conyugal;
III. Posesión exclusiva de la víctima sobre el inmueble que sirvió de domicilio;
IV. Embargo preventivo de bienes del agresor, que deberá inscribirse con carácter temporal en el
Registro Público de la Propiedad, a efecto de garantizar las obligaciones alimentarias, y
V. Obligación alimentaria provisional e inmediata.
Serán tramitadas ante los juzgados de lo familiar o a falta de éstos en los juzgados civiles que corresponda.

ARTÍCULO 33. - Corresponde a las autoridades jurisdiccionales competentes valorar las órdenes y la determinación de medidas similares en sus resoluciones o

sentencias. Lo anterior con motivo de los juicios o procesos que en materia civil, familiar o penal, se estén ventilando en los tribunales competentes.

ARTÍCULO 34. - Las personas mayores de 12 años de edad podrán solicitar a las autoridades competentes que los representen en sus solicitudes y acciones, a efecto de que las autoridades correspondientes puedan de manera oficiosa dar el otorgamiento de las órdenes; quienes sean menores de 12 años, sólo podrán solicitar las órdenes a través de sus representantes legales.

TITULO III CAPÍTULO I
DEL SISTEMA NACIONAL PARA PREVENIR, ATENDER, SANCIONAR Y ERRADICAR LA VIOLENCIA CONTRA LAS MUJERES

ARTÍCULO 35. - La Federación, las entidades federativas, el Distrito Federal y los municipios, se coordinarán para la integración y funcionamiento del Sistema, el cual tiene por objeto la conjunción de esfuerzos, instrumentos, políticas, servicios y acciones interinstitucionales para la prevención, atención, sanción y erradicación de la violencia contra las mujeres.
Todas las medidas que lleve a cabo el Estado deberán ser realizadas sin discriminación alguna. Por ello, considerará el idioma, edad, condición social, preferencia sexual, o cualquier otra condición, para que puedan acceder a las políticas públicas en la materia.

ARTÍCULO 36. - El Sistema se conformará por las y los titulares de: I. La Secretaría de Gobernación, quien lo presidirá;
II. La Secretaría de Desarrollo Social;
III. La Secretaría de Seguridad Pública;
IV. La Procuraduría General de la República;
V. La Secretaría de Educación Pública;
VI. La Secretaría de Salud;
VII. El Instituto Nacional de las Mujeres, quien ocupará la Secretaría Ejecutiva del Sistema; VIII. El Consejo Nacional para Prevenir la Discriminación;
IX. El Sistema Nacional para el Desarrollo Integral de la Familia, y
X. Los mecanismos para el adelanto de las mujeres en las entidades federativas.

ARTÍCULO 37. - La Secretaría Ejecutiva del Sistema elaborará el proyecto de reglamento para el funcionamiento del mismo y lo presentará a sus integrantes para su consideración y aprobación en su caso.

CAPÍTULO II
DEL PROGRAMA INTEGRAL PARA PREVENIR, ATENDER, SANCIONAR Y ERRADICAR LA VIOLENCIA CONTRA LAS MUJERES

ARTÍCULO 38. - El Programa contendrá las acciones con perspectiva de género para:
I. Impulsar y fomentar el conocimiento y el respeto a los derechos humanos de las mujeres;

II. Transformar los modelos socioculturales de conducta de mujeres y hombres, incluyendo la formulación de programas y acciones de educación formales y no formales, en todos los niveles educativos y de instrucción, con la finalidad de prevenir, atender y erradicar las conductas estereotipadas que permiten, fomentan y toleran la violencia contra las mujeres;
III. Educar y capacitar en materia de derechos humanos al personal encargado de la procuración de justicia, policías y demás funcionarios encargados de las políticas de prevención, atención, sanción y eliminación de la violencia contra las mujeres;
IV. Educar y capacitar en materia de derechos humanos de las mujeres al personal encargado de la impartición de justicia, a fin de dotarles de instrumentos que les permita juzgar con perspectiva de género;
V. Brindar los servicios especializados y gratuitos para la atención y protección a las víctimas, por medio de las autoridades y las instituciones públicas o privadas;
VI. Fomentar y apoyar programas de educación pública y privada, destinados a concientizar a la sociedad sobre las causas y las consecuencias de la violencia contra las mujeres;
VII. Diseñar programas de atención y capacitación a víctimas que les permita participar plenamente en todos los ámbitos de la vida;
VIII. Vigilar que los medios de comunicación no fomenten la violencia contra las mujeres y que favorezcan la erradicación de todos los tipos de violencia, para fortalecer el respeto a los derechos humanos y la dignidad de las mujeres;
IX. Garantizar la investigación y la elaboración de diagnósticos estadísticos sobre las causas, la frecuencia y las consecuencias de la violencia contra las mujeres, con el fin de evaluar la eficacia de las medidas desarrolladas para prevenir, atender, sancionar y erradicar todo tipo de violencia;
X. Publicar semestralmente la información general y estadística sobre los casos de violencia contra las mujeres para integrar el Banco Nacional de Datos e Información sobre Casos de Violencia contra las Mujeres;
XI. Promover la inclusión prioritaria en el Plan Nacional de Desarrollo de las medidas y las políticas de gobierno para erradicar la violencia contra las mujeres;
XII. Promover la cultura de denuncia de la violencia contra las mujeres en el marco de la eficacia de las instituciones para garantizar su seguridad y su integridad, y
XIII. Diseñar un modelo integral de atención a los derechos humanos y ciudadanía de las mujeres que deberán instrumentar las instituciones, los centros de atención y los refugios que atiendan a víctimas.

ARTÍCULO 39. - El Ejecutivo Federal propondrá en el Proyecto de Presupuesto de Egresos de la Federación asignar una partida presupuestaria para garantizar el cumplimiento de los objetivos del Sistema y del Programa previstos en la presente ley.

CAPÍTULO III
DE LA DISTRIBUCIÓN DE COMPETENCIAS EN MATERIA DE PREVENCIÓN, ATENCIÓN, SANCIÓN Y ERRADICACIÓN DE LA VIOLENCIA CONTRA LAS MUJERES

ARTÍCULO 40. La Federación, las entidades federativas, el Distrito Federal y los municipios, coadyuvarán para el cumplimiento de los objetivos de esta ley de

conformidad con las competencias previstas en el presente ordenamiento y demás instrumentos legales aplicables.

ARTÍCULO 41. Son facultades y obligaciones de la Federación:
I. Garantizar el ejercicio pleno del derecho de las mujeres a una vida libre de violencia;
II. Formular y conducir la política nacional integral desde la perspectiva de género para prevenir, atender, sancionar y erradicar la violencia contra las mujeres;
III. Vigilar el cabal cumplimiento de la presente ley y de los instrumentos internacionales aplicables;
IV. Elaborar, coordinar y aplicar el Programa a que se refiere la ley, auxiliándose de las demás
autoridades encargadas de implementar el presente ordenamiento legal;
V. Educar en los derechos humanos a las mujeres en su lengua materna;
VI. Asegurar la difusión y promoción de los derechos de las mujeres indígenas con base en el reconocimiento de la composición pluricultural de la nación;
VII. Vigilar que los usos y costumbres de toda la sociedad no atenten contra los derechos humanos de las mujeres;
VIII. Coordinar la creación de Programas de reeducación y reinserción social con perspectiva de género para agresores de mujeres;
IX. Garantizar una adecuada coordinación entre la Federación, las entidades federativas, el Distrito Federal y los municipios, con la finalidad de erradicar la violencia contra las mujeres;
X. Realizar a través del Instituto Nacional de las Mujeres y con el apoyo de las instancias locales, campañas de información, con énfasis en la doctrina de la protección integral de los derechos humanos de las mujeres, en el conocimiento de las leyes y las medidas y los programas que las protegen, así como de los recursos jurídicos que las asisten;
XI. Impulsar la formación y actualización de acuerdos interinstitucionales de coordinación entre las diferentes instancias de gobierno, de manera que sirvan de cauce para lograr la atención integral de las víctimas;
XII. Celebrar convenios de cooperación, coordinación y concertación en la materia;
XIII. Coadyuvar con las instituciones públicas o privadas dedicadas a la atención de víctimas;
XIV. Ejecutar medidas específicas, que sirvan de herramientas de acción para la prevención, atención y erradicación de la violencia contra las mujeres en todos los ámbitos, en un marco de integralidad y promoción de los derechos humanos;
XV. Promover y realizar investigaciones con perspectiva de género sobre las causas y las consecuencias de la violencia contra las mujeres;
XVI. Evaluar y considerar la eficacia de las acciones del Programa, con base en los resultados de las investigaciones previstas en la fracción anterior;
XVII. Rendir un informe anual sobre los avances del Programa, ante el H. Congreso de la Unión;
XVIII. Vigilar que los medios de comunicación no promuevan imágenes estereotipadas de mujeres y hombres, y eliminen patrones de conducta generadores de violencia;

XIX. Desarrollar todos los mecanismos necesarios para el cumplimiento de la presente ley, y XX. Las demás que le confieran esta ley u otros ordenamientos aplicables.
Sección Segunda. De la Secretaría de Gobernación ARTÍCULO 42. Corresponde a la Secretaría de Gobernación:
I. Presidir el Sistema y declarar la alerta de violencia de género contra las mujeres;
II. Diseñar la política integral con perspectiva de género para promover la cultura del respeto a los derechos humanos de las mujeres;
III. Elaborar el Programa en coordinación con las demás autoridades integrantes del Sistema;
IV. Formular las bases para la coordinación entre las autoridades federales, locales, del Distrito Federal y municipales para la prevención, atención, sanción y erradicación de la violencia contra las mujeres;
V. Coordinar y dar seguimiento a las acciones de los tres órdenes de gobierno en materia de protección, atención, sanción y erradicación de la violencia contra las mujeres;
VI. Coordinar y dar seguimiento a los trabajos de promoción y defensa de los derechos humanos de las mujeres, que lleven a cabo las dependencias y entidades de la Administración Pública Federal;
VII. Establecer, utilizar, supervisar y mantener todos los instrumentos y acciones encaminados al mejoramiento del Sistema y del Programa;
VIII. Ejecutar y dar seguimiento a las acciones del Programa, con la finalidad de evaluar su eficacia y rediseñar las acciones y medidas para avanzar en la eliminación de la violencia contra las mujeres;
IX. Diseñar, con una visión transversal, la política integral orientada a la prevención, atención, sanción y erradicación de los delitos violentos contra las mujeres;
X. Vigilar que los medios de comunicación favorezcan la erradicación de todos los tipos de violencia y se fortalezca la dignidad de las mujeres;
XI. Sancionar conforme a la ley a los medios de comunicación que no cumplan con lo estipulado en la fracción anterior;
XII. Realizar un Diagnóstico Nacional y otros estudios complementarios de manera periódica con perspectiva de género sobre todas las formas de violencia contra las mujeres y las niñas, en todos los ámbitos, que proporcione información objetiva para la elaboración de políticas gubernamentales en materia de prevención, atención, sanción y erradicación de la violencia contra las mujeres.
XIII. Difundir a través de diversos medios, los resultados del Sistema y del Programa a los que se refiere esta ley;
XIV. Celebrar convenios de cooperación, coordinación y concertación en la materia, y 13 de 24
XV. Las demás previstas para el cumplimiento de la presente ley.
Sección Tercera. De la Secretaría de Desarrollo Social

ARTÍCULO 43. - Corresponde a la Secretaría de Desarrollo Social:
I. Fomentar el desarrollo social desde la visión de protección integral de los derechos humanos de las mujeres con perspectiva de género, para garantizarles una vida libre de violencia;

II. Coadyuvar en la promoción de los Derechos Humanos de las Mujeres;
III. Formular la política de desarrollo social del estado considerando el adelanto de las mujeres y su plena participación en todos los ámbitos de la vida;
IV. Realizar acciones tendientes a mejorar las condiciones de las mujeres y sus familias que se encuentren en situación de exclusión y de pobreza;
V. Promover políticas de igualdad de condiciones y oportunidades entre mujeres y hombres, para lograr el adelanto de las mujeres para su empoderamiento y la eliminación de las brechas y desventajas de género;
VI. Promover políticas de prevención y atención de la violencia contra las mujeres;
VII. Establecer, utilizar, supervisar y mantener todos los instrumentos y acciones encaminados al mejoramiento del Sistema y del Programa;
VIII. Celebrar convenios de cooperación, coordinación y concertación en la materia, y IX. Las demás previstas para el cumplimiento de la presente ley.
Sección Cuarta. De la Secretaría de Seguridad Pública ARTÍCULO 44. - Corresponde a la Secretaría de Seguridad Pública:
I. Capacitar al personal de las diferentes instancias policiales para atender los casos de violencia contra las mujeres;
II. Tomar medidas y realizar las acciones necesarias, en coordinación con las demás autoridades, para alcanzar los objetivos previstos en la presente ley;
III. Integrar el Banco Nacional de Datos e Información sobre Casos de Violencia contra las Mujeres; IV. Diseñar la política integral para la prevención de delitos violentos contra las mujeres, en los ámbitos público y privado;
V. Establecer las acciones y medidas que se deberán tomar para la reeducación y reinserción social del agresor;
VI. Ejecutar y dar seguimiento a las acciones del Programa que le correspondan;
VII. Formular acciones y programas orientados a fomentar la cultura del respeto a los derechos humanos de las mujeres;
VIII. Diseñar, con una visión transversal, la política integral con perspectiva de género orientada a la prevención, atención, sanción y erradicación de los delitos violentos contra las mujeres;
IX. Establecer, utilizar, supervisar y mantener todos los instrumentos y acciones encaminados al mejoramiento del Sistema y del Programa;
X. Celebrar convenios de cooperación, coordinación y concertación en la materia, y XI. Las demás previstas para el cumplimiento de la presente ley.
Sección Quinta. De la Secretaría de Educación Pública ARTÍCULO 45. - Corresponde a la Secretaría de Educación Pública:
I. Definir en las políticas educativas los principios de igualdad, equidad y no discriminación entre mujeres y hombres y el respeto pleno a los derechos humanos;
II. Desarrollar programas educativos, en todos los niveles de escolaridad, que fomenten la cultura de una vida libre de violencia contra las mujeres, así como el respeto a su dignidad;
III. Garantizar acciones y mecanismos que favorezcan el adelanto de las mujeres en todas las etapas del proceso educativo;
IV. Garantizar el derecho de las niñas y mujeres a la educación: a la alfabetización y al acceso, permanencia y terminación de estudios en todos los niveles. A través de la obtención de becas y otras subvenciones;

V. Desarrollar investigación multidisciplinaria encaminada a crear modelos de detección de la violencia contra las mujeres en los centros educativos;
VI. Capacitar al personal docente en derechos humanos de las mujeres y las niñas;
VII. Incorporar en los programas educativos, en todos los niveles de la instrucción, el respeto a los derechos humanos de las mujeres, así como contenidos educativos tendientes a modificar los modelos de conducta sociales y culturales que impliquen prejuicios y que estén basados en la idea de la inferioridad o superioridad de uno de los sexos y en funciones estereotipadas asignadas a las mujeres y a los hombres;
VIII. Formular y aplicar programas que permitan la detección temprana de los problemas de violencia contra las mujeres en los centros educativos, para que se dé una primera respuesta urgente a las alumnas que sufren algún tipo de violencia;
IX. Establecer como un requisito de contratación a todo el personal de no contar con algún antecedente de violencia contra las mujeres;
X. Diseñar y difundir materiales educativos que promuevan la prevención y atención de la violencia contra las mujeres;
XI. Proporcionar acciones formativas a todo el personal de los centros educativos, en materia de derechos humanos de las niñas y las mujeres y políticas de prevención, atención, sanción y erradicación de la violencia contra las mujeres;
XII. Eliminar de los programas educativos los materiales que hagan apología de la violencia contra las mujeres o contribuyan a la promoción de estereotipos que discriminen y fomenten la desigualdad entre mujeres y hombres;
XIII. Establecer, utilizar, supervisar y mantener todos los instrumentos y acciones encaminados al mejoramiento del Sistema y del Programa;
XIV. Diseñar, con una visión transversal, la política integral con perspectiva de género orientada a la prevención, atención, sanción y erradicación de los delitos violentos contra las mujeres;
XV. Celebrar convenios de cooperación, coordinación y concertación en la materia, y XVI. Las demás previstas para el cumplimiento de la presente ley.
Sección Sexta. De la Secretaría de Salud ARTÍCULO 46. - Corresponde a la Secretaría de Salud:
I. En el marco de la política de salud integral de las mujeres, diseñar con perspectiva de género, la política de prevención, atención y erradicación de la violencia en su contra;
II. Brindar por medio de las instituciones del sector salud de manera integral e interdisciplinaria atención médica y psicológica con perspectiva de género a las víctimas;
III. Crear programas de capacitación para el personal del sector salud, respecto de la violencia contra las mujeres y se garanticen la atención a las víctimas y la aplicación de la NOM 190-SSA1-1999: Prestación de servicios de salud. Criterios para la atención médica de la violencia familiar;
IV. Establecer programas y servicios profesionales y eficaces, con horario de veinticuatro horas en las dependencias públicas relacionadas con la atención de la violencia contra las mujeres;
V. Brindar servicios reeducativos integrales a las víctimas y a los agresores, a fin de que logren estar en condiciones de participar plenamente en la vida pública, social y privada;

VI. Difundir en las instituciones del sector salud, material referente a la prevención y atención de la violencia contra las mujeres;
VII. Canalizar a las víctimas a las instituciones que prestan atención y protección a las mujeres;
VIII. Mejorar la calidad de la atención, que se preste a las mujeres víctimas;
IX. Participar activamente, en la ejecución del Programa, en el diseño de nuevos modelos de prevención, atención y erradicación de la violencia contra las mujeres, en colaboración con las demás autoridades encargadas de la aplicación de la presente ley;
X. Asegurar que en la prestación de los servicios del sector salud sean respetados los derechos humanos de las mujeres;
XI. Capacitar al personal del sector salud, con la finalidad de que detecten la violencia contra las mujeres;
XII. Apoyar a las autoridades encargadas de efectuar investigaciones en materia de violencia contra las mujeres, proporcionando la siguiente información:
a) La relativa al número de víctimas que se atiendan en los centros y servicios hospitalarios; b) La referente a las situaciones de violencia que sufren las mujeres;
c) El tipo de violencia por la cual se atendió a la víctima;
d) Los efectos causados por la violencia en las mujeres, y
e) Los recursos erogados en la atención de las víctimas.
XIII. Celebrar convenios de cooperación, coordinación y concertación en la materia, y XIV. Las demás previstas para el cumplimiento de la presente ley.
Sección Séptima. De la Procuraduría General de la República
ARTÍCULO 47. - Corresponde a la Procuraduría General de la República:
I. Promover la formación y especialización de Agentes de la Policía Federal Investigadora, Agentes del Ministerio Público y de todo el personal encargado de la procuración de justicia en materia de derechos humanos de las mujeres;
II. Proporcionar a las víctimas orientación y asesoría para su eficaz atención y protección, de conformidad con la Ley Orgánica de la Procuraduría General de la República, su Reglamento y demás ordenamientos aplicables;
III. Dictar las medidas necesarias para que la Víctima reciba atención médica de emergencia;
IV. Proporcionar a las instancias encargadas de realizar estadísticas las referencias necesarias sobre el número de víctimas atendidas;
V. Brindar a las víctimas la información integral sobre las instituciones públicas o privadas encargadas de su atención;
VI. Proporcionar a las víctimas información objetiva que les permita reconocer su situación;
VII. Promover la cultura de respeto a los derechos humanos de las mujeres y garantizar la seguridad
de quienes denuncian;
VIII. Celebrar convenios de cooperación, coordinación y concertación en la materia, y IX. Las demás previstas para el cumplimiento de la presente ley.
Sección Octava. Del Instituto Nacional de las Mujeres ARTÍCULO 48. Corresponde al Instituto Nacional de las Mujeres:
I. Fungir como Secretaría Ejecutiva del Sistema, a través de su titular;

II. Integrar las investigaciones promovidas por las dependencias de la Administración Pública Federal sobre las causas, características y consecuencias de la violencia en contra de las mujeres, así como la evaluación de las medidas de prevención, atención y erradicación, y la información derivada a cada una de las instituciones encargadas de promover los derechos humanos de las mujeres en las entidades federativas, el Distrito Federal o municipios. Los resultados de dichas investigaciones serán dados a conocer públicamente para tomar las medidas pertinentes hacia la erradicación de la violencia;
III. Proponer a las autoridades encargadas de la aplicación de la presente ley, los programas, las medidas y las acciones que consideren pertinentes, con la finalidad de erradicar la violencia contra las mujeres;
IV. Colaborar con las instituciones del Sistema en el diseño y evaluación del modelo de atención a víctimas en los refugios;
V. Impulsar la creación de unidades de atención y protección a las víctimas de violencia prevista en la ley;
VI. Canalizar a las víctimas a programas reeducativos integrales que les permitan participar activamente en la vida pública, privada y social;
VII. Promover y vigilar que la atención ofrecida en las diversas instituciones públicas o privadas, sea proporcionada por especialistas en la materia, sin prejuicios ni discriminación alguna;
VIII. Difundir la cultura de respeto a los derechos humanos de las mujeres y promover que las instancias de procuración de justicia garanticen la integridad física de quienes denuncian;
IX. Celebrar convenios de cooperación, coordinación y concertación en la materia, y X. Las demás previstas para el cumplimiento de la ley.
Sección Novena. De las Entidades Federativas
ARTÍCULO 49. Corresponde a las entidades federativas y al Distrito Federal, de conformidad con lo dispuesto por esta ley y los ordenamientos locales aplicables en la materia:
I. Instrumentar y articular sus políticas públicas en concordancia con la política nacional integral desde la perspectiva de género para prevenir, atender, sancionar y erradicar la violencia contra las mujeres;
II. Ejercer sus facultades reglamentarias para la aplicación de la presente ley;
III. Coadyuvar en la adopción y consolidación del Sistema;
IV. Participar en la elaboración del Programa;
V. Reforzar a las instituciones públicas y privadas que prestan atención a las víctimas;
VI. Integrar el Sistema Estatal de Prevención, Erradicación y Sanción de la Violencia contra las Mujeres e incorporar su contenido al Sistema;
VII. Promover, en coordinación con la Federación, programas y proyectos de atención, educación, capacitación, investigación y cultura de los derechos humanos de las mujeres y de la no violencia, de acuerdo con el Programa;
VIII. Impulsar programas locales para el adelanto y desarrollo de las mujeres y mejorar su calidad de vida;
IX. Proveer de los recursos presupuestarios, humanos y materiales, en coordinación con las autoridades que integran los sistemas locales, a los programas estatales y el Programa;

X. Impulsar la creación de refugios para las víctimas conforme al modelo de atención diseñado por el Sistema;
XI. Promover programas de información a la población en la materia;
XII. Impulsar programas reeducativos integrales de los agresores;
XIII. Difundir por todos los medios de comunicación el contenido de esta ley;
XIV. Rendir un informe anual sobre los avances de los programas locales;
XV. Promover investigaciones sobre las causas y las consecuencias de la violencia contra las mujeres;
XVI. Revisar y evaluar la eficacia de las acciones, las políticas públicas, los programas estatales, con base en los resultados de las investigaciones previstas en la fracción anterior;
XVII. Impulsarlaparticipacióndelasorganizacionesprivadasdededicadasalaprom ociónydefensa de los derechos humanos de las mujeres, en la ejecución de los programas estatales;
XVIII. Recibir de las organizaciones privadas, las propuestas y recomendaciones sobre la prevención, atención y sanción de la violencia contra mujeres, a fin de mejorar los mecanismos para su erradicación;
XIX. Proporcionar a las instancias encargadas de realizar estadísticas, la información necesaria para la elaboración de éstas;
XX. Impulsar reformas, en el ámbito de su competencia, para el cumplimiento de los objetivos de la presente ley, así como para establecer como agravantes los delitos contra la vida y la integridad cuando estos sean cometidos contra mujeres, por su condición de género;
XXI. Celebrar convenios de cooperación, coordinación y concertación en la materia, y
XXII. Las demás aplicables a la materia, queles conceda la leyu otro sordenamientos legales.
Las autoridades federales, harán las gestiones necesarias para propiciar que las autoridades locales reformen su legislación, para considerar como agravantes los delitos contra la vida y la integridad corporal cometidos contra mujeres.
Sección Décima. De los Municipios

ARTÍCULO 50. - Corresponde a los municipios, de conformidad con esta ley y las leyes locales en la materia y acorde con la perspectiva de género, las siguientes atribuciones:
I. Instrumentar y articular, en concordancia con la política nacional y estatal, la política municipal orientada a erradicar la violencia contra las mujeres;
II. Coadyuvar con la Federación y las entidades federativas, en la adopción y consolidación del Sistema;
III. Promover, en coordinación con las entidades federativas, cursos de capacitación a las personas que atienden a víctimas;
IV. Ejecutar las acciones necesarias para el cumplimiento del Programa;
V. Apoyar la creación de programas de reeducación integral para los agresores;
VI. Promover programas educativos sobre la igualdad y la equidad entre los géneros para eliminar la violencia contra las mujeres;
VII. Apoyar la creación de refugios seguros para las víctimas;

VIII. Participar y coadyuvar en la prevención, atención y erradicación de la violencia contra las mujeres;
IX. Llevar a cabo, de acuerdo con el Sistema, programas de información a la población respecto de la violencia contra las mujeres;
X. Celebrar convenios de cooperación, coordinación y concertación en la materia, y
XI. La atención de los demás asuntos que en materia de violencia contra las mujeres que les conceda esta ley u otros ordenamientos legales.

CAPÍTULO IV
DE LA ATENCIÓN A LAS VÍCTIMAS

ARTÍCULO 51. - Las autoridades en el ámbito de sus respectivas competencias deberán prestar atención a las víctimas, consistente en:
I. Fomentar la adopción y aplicación de acciones y programas, por medio de los cuales se les brinde protección;
II. Promover la atención a víctimas por parte de las diversas instituciones del sector salud, así como de atención y de servicio, tanto públicas como privadas;
III. Proporcionar a las víctimas, la atención médica, psicológica y jurídica, de manera integral, gratuita y expedita;
IV. Proporcionar un refugio seguro a las víctimas, y
V. Informar a la autoridad competente de los casos de violencia que ocurran en los centros educativos.

ARTÍCULO 52. - Las víctimas de cualquier tipo de violencia tendrán los derechos siguientes:
I. Ser tratada con respeto a su integridad y al ejercicio pleno de sus derechos;
II. Contar con protección inmediata y efectiva por parte de las autoridades;
III. Recibir información veraz y suficiente que les permita decidir sobre las opciones de atención; IV. Contar con asesoría jurídica gratuita y expedita;
V. Recibir información médica y psicológica;
VI. Contar con un refugio, mientras lo necesite;
VII. Ser valoradas y educadas libres de estereotipos de comportamiento y prácticas sociales y culturales basadas en conceptos de inferioridad o subordinación, y
VIII. En los casos de violencia familiar, las mujeres que tengan hijas y/o hijos podrán acudir a los refugios con éstos.

ARTÍCULO 53. - El Agresor deberá participar obligatoriamente en los programas de reeducación integral, cuando se le determine por mandato de autoridad competente.

CAPÍTULO V
DE LOS REFUGIOS PARA LAS VICTIMAS DE VIOLENCIA

ARTÍCULO 54. - Corresponde a los refugios, desde la perspectiva de género:
I. Aplicar el Programa;
II. Velar por la seguridad de las mujeres que se encuentren en ellos;

III. Proporcionar a las mujeres la atención necesaria para su recuperación física y psicológica, que les permita participar plenamente en la vida pública, social y privada;
IV. Dar información a las víctimas sobre las instituciones encargadas de prestar asesoría jurídica gratuita;
V. Brindar a las víctimas la información necesaria que les permita decidir sobre las opciones de atención;
VI. Contar con el personal debidamente capacitado y especializado en la materia, y
VII. Todas aquellas inherentes a la prevención, protección y atención de las personas que se encuentren en ellos.

ARTÍCULO 55. - Los refugios deberán ser lugares seguros para las víctimas, por lo que no se podrá proporcionar su ubicación a personas no autorizadas para acudir a ellos.

ARTÍCULO 56. - Los refugios deberán prestar a las víctimas y, en su caso, a sus hijas e hijos los siguientes servicios especializados y gratuitos:
I. Hospedaje;
II. Alimentación;
III. Vestido y calzado;
IV. Servicio médico;
V. Asesoría jurídica;
VI. Apoyo psicológico;
Última Reforma DOF 20-01-2009
VII. Programas reeducativos integrales a fin de que logren estar en condiciones de participar plenamente en la vida pública, social y privada;
VIII. Capacitación, para que puedan adquirir conocimientos para el desempeño de una actividad laboral, y
IX. Bolsa de trabajo, con la finalidad de que puedan tener una actividad laboral remunerada en caso de que lo soliciten.

ARTÍCULO 57. - La permanencia de las víctimas en los refugios no podrá ser mayor a tres meses, a menos de que persista su inestabilidad física, psicológica o su situación de riesgo.

ARTÍCULO 58. - Para efectos del artículo anterior, el personal médico, psicológico y jurídico del refugio evaluará la condición de las víctimas.

ARTÍCULO 59. - En ningún caso se podrá mantener a las víctimas en los refugios en contra de su voluntad.

TRANSITORIOS

ARTÍCULO PRIMERO. - El presente Decreto entrará en vigor el día siguiente al de su publicación en el Diario Oficial de la Federación.

ARTÍCULO SEGUNDO. - El Ejecutivo Federal emitirá el Reglamento de la ley dentro de los 90 días siguientes a la entrada en vigor del presente Decreto.

ARTÍCULO TERCERO. - El Sistema Nacional a que se refiere esta ley, se integrará dentro de los 60 días siguientes a la entrada en vigor del presente Decreto.

ARTÍCULO CUARTO. - El Reglamento del Sistema deberá expedirse dentro de los 90 días siguientes a la entrada en vigor del presente Decreto.

ARTÍCULO QUINTO. - El Diagnóstico Nacional a que se refiere la fracción XII del artículo 44 de la ley deberá realizarse dentro de los 365 días siguientes a la integración del Sistema.

ARTÍCULO SEXTO. - Los recursos para llevar a cabo los programas y la implementación de las acciones que se deriven de la presente ley, se cubrirán con cargo al presupuesto autorizado a las dependencias, entidades y órganos desconcentrados del Ejecutivo Federal, Poderes Legislativo y Judicial, órganos autónomos, estados y municipios, para el presente ejercicio fiscal y los subsecuentes, asimismo, no requerirán de estructuras orgánicas adicionales por virtud de los efectos de la misma.

ARTÍCULO SÉPTIMO. - El Banco Nacional de Datos e Información sobre Casos de Violencia contra las Mujeres a que refiere la fracción III del artículo 45 deberá integrarse dentro de los 365 días siguientes a la conformación del Sistema.

ARTÍCULO OCTAVO. - En un marco de coordinación, las Legislaturas de los Estados, promoverán las reformas necesarias en la Legislación Local, previstas en las fracciones II y XX del artículo 49, dentro de un término de 6 meses, contados a partir de la entrada en vigor de la presente Ley.
México, D.F., a 19 de diciembre de 2006. - Dip. Jorge Zermeño Infante, Presidente. - Sen. Manlio Fabio Beltrones Rivera, Presidente. - Dip. Maria Eugenia Jimenez Valenzuela, Secretaria. - Sen. Renán Cleominio Zoreda Novelo, Secretario. - Rúbricas."
En cumplimiento de lo dispuesto por la fracción I del Artículo 89 de la Constitución Política de los Estados Unidos Mexicanos, y para su debida publicación y observancia, expido el presente Decreto en la Residencia del Poder Ejecutivo Federal, en la Ciudad de México, Distrito Federal, a los treinta y un días del mes de enero de dos mil siete. - Felipe de Jesús Calderón Hinojosa. - Rúbrica. - El Secretario de Gobernación, Francisco Javier Ramírez Acuña. - Rúbrica.

REFORMADA, P.O. 23 DE OCTUBRE DE 2019) (F. DE E. P.O. 27 DE NOVIEMBRE DE 2019)
VIII Bis. - Violencia Obstétrica: Es toda conducta u omisión por parte del personal de servicios de salud que tenga como consecuencia la pérdida de la autonomía y capacidad de la mujer para decidir libremente sobre su parto y sexualidad y que por negligencia y/o una deshumanizada atención médica durante el embarazo,

parto o puerperio dañe, lastime o denigre a las mujeres de cualquier edad, que le genere una afectación física, psicológica o moral, que incluso llegue a provocar la pérdida de la vida de la mujer o, en su caso, del producto de la gestación o del recién nacido, derivado de la prestación de servicios médicos, mediante:

a) No atender oportuna y eficazmente las emergencias obstétricas;
b) No otorgar información suficiente sobre los riesgos de la cesárea de conformidad con la evidencia científica y las recomendaciones de la Organización Mundial de la Salud;
c) Revisiones y prácticas de salud que consideren personal adicional no necesario;
d) La imposición de métodos anticonceptivos o de esterilización sin que medie el consentimiento voluntario, expreso e informado de la mujer; en caso de ser menor de edad o que sufran alguna discapacidad mental, de sus padres o tutor;
e) La práctica del parto vía cesárea existiendo posibilidad para efectuar parto natural y sin haber obtenido la renuncia voluntaria expresa e informada a la mujer de esta posibilidad;
f) Alterar el proceso natural del parto de bajo riesgo, mediante el uso de técnicas de aceleración, sin obtener el consentimiento voluntario, expreso e informado de la mujer;
g) Obstaculizar el apego precoz del niño o niña con su madre sin causa médica justificada, negándole la posibilidad de cargarlo o amamantarlo inmediatamente al nacer;
h) Promover fórmulas lácteas en sustitución de la leche materna;
i) No realizar las gestiones necesarias para que las mujeres que hubieren sufrido un aborto involuntario, reciban la debida atención médica y psicológica; y
j) Todas aquellas previstas por la Ley General de Acceso de las Mujeres a una Vida Libre de Violencia.

Paraguay

LEY N° 5777/2016
DE PROTECCIÓN INTEGRAL A LAS MUJERES, CONTRA TODA FORMA DE VIOLENCIA
EL CONGRESO DE LA NACIÓN PARAGUAYA SANCIONA CON FUERZA DE LEY

CAPÍTULO I
OBJETO DE LA LEY Y PRINCIPIOS GENERALES

Artículo 1°. - Objeto. La presente Ley tiene por objeto establecer políticas y estrategias de prevención de la violencia hacia la mujer, mecanismos de atención y medidas de protección, sanción y reparación integral, tanto en el ámbito público como en el privado.

Artículo 2°. - Finalidad. La presente Ley tiene por finalidad promover y garantizar el derecho de las mujeres a una vida libre de violencia.

Artículo 3°. - Ámbito de aplicación. La presente Ley se aplicará a las mujeres, sin ningún tipo de discriminación, frente a actos u omisiones que impliquen cualquier tipo de violencia descripta en esta Ley y que se produzca en los siguientes ámbitos:
a) Dentro de la familia o unidad doméstica cuando exista una relación interpersonal de pareja presente o pasada, de parentesco o de convivencia entre el autor y la mujer agredida.
b) En la comunidad, sin necesidad de que exista una relación o vínculo de ningún tipo entre la persona o personas agresoras y la mujer.
c) Que sea perpetrada o tolerada por el Estado, a través de sus agentes o terceras personas con su consentimiento en cualquier lugar que se produzca.

Artículo 4°. - Derechos Protegidos. La protección de la mujer en el marco de esta Ley establece los siguientes derechos:
a) El derecho a la vida, a la integridad física y psicológica;
b) El derecho a la dignidad;
c) El derecho a no ser sometida a torturas o a tratos o penas crueles, inhumanos o degradantes;
d) El derecho a la libertad y a la seguridad personal;
e) El derecho a la igualdad ante la Ley;
f) El derecho a la igualdad en la familia;
g) El derecho a la salud física y mental;
h) El derecho a vivir en un medio ambiente seguro y saludable;
i) El derecho a la libertad de pensamientos, conciencia y expresión;
j) El derecho a la propiedad;
k) El derecho a la intimidad y la imagen;
l) El derecho a la planificación familiar y de la salud materno infantil;
m) Los derechos a la educación, al trabajo digno y la seguridad social;
n) El derecho a participar en los asuntos públicos;
ñ) El derecho al acceso a la justicia y a un recurso sencillo, rápido y efectivo ante los tribunales competentes, que la proteja; y,
o) El derecho a las garantías judiciales.
La enunciación de los derechos protegidos contenidos en este artículo no debe entenderse taxativamente, ni excluir otros que, siendo inherentes a la personalidad humana, no figuren expresamente protegidos.

Artículo 5°. - Definiciones. A los efectos de la presente Ley, se entenderá por:
a) Violencia contra la mujer:
Es la conducta que cause muerte, daño o sufrimiento físico, sexual, psicológico, patrimonial o económico a la mujer, basada en su condición de tal, en cualquier ámbito, que sea ejercida en el marco de relaciones desiguales de poder y discriminatorias.
b) Discriminación contra la mujer:
Toda distinción, exclusión o restricción contra la mujer que tenga por objeto o resultado menoscabar o anular el reconocimiento, goce o ejercicio de los derechos, en condiciones de igualdad entre hombres y mujeres, en las esferas: política, económica, social, cultural, civil y laboral, ya sea en el sector público o privado, o en cualquier otro ámbito.

Artículo 6º. - Promoción de políticas públicas. Formas de violencia. Las autoridades de aplicación de la presente Ley establecerán, promocionarán y difundirán políticas públicas dirigidas a prevenir, disminuir y eliminar las siguientes formas de violencia perpetradas contra la mujer:
a) Violencia feminicida. Es la acción que atenta contra el derecho fundamental a la vida y causa o intenta causar la muerte de la mujer y que está motivada por su condición de tal, tanto en el ámbito público como privado.
b) Violencia física. Es la acción que se emplea contra el cuerpo de la mujer produciendo dolor, daño en su salud o riesgo de producirlo y cualquier otra forma de maltrato que afecte su integridad física.
c) Violencia psicológica. Acto de desvalorización, humillación, intimidación, coacción, presión, hostigamiento, persecución, amenazas, control y vigilancia del comportamiento y aislamiento impuesto a la mujer.
d) Violencia sexual. Es la acción que implica la vulneración del derecho de la mujer de decidir libremente acerca de su vida sexual, a través de cualquier forma de amenaza, coacción o intimidación.
e) Violencia contra los derechos reproductivos. Es la acción que impide, limita o vulnera el derecho de la mujer a:
1. Decidir libremente el número de hijos que desea tener y el intervalo entre los nacimientos;
2. Recibir información, orientación, atención integral y tratamiento durante el embarazo o pérdida del mismo, parto, puerperio y lactancia;
3. Ejercer una maternidad segura; o,
4. Elegir métodos anticonceptivos seguros o que impliquen la pérdida de autonomía o de la capacidad de decidir libremente sobre los métodos anticonceptivos a ser adoptados.
El reconocimiento de los derechos reproductivos, en ningún caso, podrá invocarse para la interrupción del embarazo.
f) Violencia patrimonial y económica. Acción u omisión que produce daño o menoscabo en los bienes, valores, recursos o ingresos económicos propios de la mujer o los gananciales por disposición unilateral, fraude, desaparición, ocultamiento, destrucción u otros medios, así como el negar o impedir de cualquier modo realizar actividades laborales fuera del hogar o privarle de los medios indispensables para vivir.
g) Violencia laboral. Es la acción de maltrato o discriminación hacia la mujer en el ámbito del trabajo, ejercida por superiores o compañeros de igual o inferior jerarquía a través de:
1. Descalificaciones humillantes;
2. Amenazas de destitución o despido injustificado;
3. Despido durante el embarazo;
4. Alusiones a la vida privada que impliquen la exposición indebida de su intimidad;
5. La imposición de tareas ajenas a sus funciones;
6. Servicios laborales fuera de horarios no pactados;
7. Negación injustificada de permisos o licencias por enfermedad, maternidad, o vacaciones;

8. Sometimiento a una situación de aislamiento social ejercidas por motivos discriminatorios de su acceso al empleo, permanencia o ascenso; o,
9. La imposición de requisitos que impliquen un menoscabo a su condición laboral y estén relacionados con su estado civil, familiar, edad y apariencia física, incluida la obligación de realizarse pruebas de Virus de Inmunodeficiencia Humana VIH/SIDA y a la prueba de embarazo.
h) Violencia política. Es la acción realizada contra la mujer que tenga como fin retardar, obstaculizar o impedir que la misma participe de la vida política en cualquiera de sus formas y ejerza los derechos previstos en esta Ley.
i) Violencia intrafamiliar. Es la acción de violencia física o psicológica ejercida en el ámbito familiar contra la mujer por su condición de tal, por parte de miembros de su grupo familiar.
Se entiende por "miembros de su grupo familiar" a los parientes sean por consanguinidad o por afinidad, al cónyuge o conviviente y a la pareja sentimental. Este vínculo incluye a las relaciones vigentes o finalizadas, no siendo requisito la convivencia.
j) Violencia obstétrica. Es la conducta ejercida por el personal de salud o las parteras empíricas sobre el cuerpo de las mujeres y de los procesos fisiológicos o patológicos presentes durante su embarazo, y las etapas relacionadas con la gestación y el parto. Es al mismo tiempo un trato deshumanizado que viola los derechos humanos de las mujeres.
k) Violencia mediática. Es la acción ejercida por los medios de comunicación social, a través de publicaciones u otras formas de difusión o reproducción de mensajes, contenidos e imágenes estereotipadas que promuevan la cosificación, sumisión o explotación de mujeres o que presenten a la violencia contra la mujer como una conducta aceptable. Se entenderá por "cosificación" a la acción de reducir a la mujer a la condición de cosa.
l) Violencia telemática. Es la acción por medio de la cual se difunden o publican mensajes, fotografías, audios, videos u otros que afecten la dignidad o intimidad de las mujeres a través de las actuales tecnologías de información y comunicación, incluido el uso de estos medios para promover la cosificación, sumisión o explotación de la mujer. Se entenderá por "cosificación" a la acción de reducir a la mujer a la condición de cosa.
m) Violencia simbólica. Consiste en el empleo o difusión de mensajes, símbolos, íconos, signos que transmitan, reproduzcan y consoliden relaciones de dominación, exclusión, desigualdad y discriminación, naturalizando la subordinación de las mujeres.
n) Violencia Institucional. Actos u omisiones cometidos por funcionarios, de cualquier institución pública o privada, que tengan como fin retardar o impedir a las mujeres el acceso a servicios públicos o privados o que en la prestación de estos se les agreda o brinde un trato discriminatorio o humillante.
ñ) Violencia contra la Dignidad. Expresión verbal o escrita de ofensa o insulto que desacredita, descalifica, desvaloriza, degrada o afecta la dignidad de las mujeres, así como los mensajes públicos de autoridades, funcionarios o particulares que justifiquen o promuevan la violencia hacia las mujeres o su discriminación en cualquier ámbito.

Artículo 7º. - Principios rectores.
Para el cumplimiento de los fines de la presente Ley, se adoptan los siguientes principios:
a) Enfoque de integralidad. La violencia hacia las mujeres como problema estructural será abordada en sus diferentes manifestaciones a partir de medidas preventivas, de atención, de protección y sanción.
b) Igualdad y no discriminación. Se garantizan la atención y protección integral a todas las mujeres sin ningún tipo de discriminación, y eliminando las barreras que impidan el ejercicio de derechos en igualdad de condiciones.
c) Las políticas públicas. Las políticas públicas incluirán medidas que tomen en cuenta las necesidades y demandas específicas de todas las mujeres, en particular de las mujeres en situación de violencia.
d) Participación ciudadana. La sociedad tiene el derecho a participar de forma protagónica para lograr la vigencia plena y efectiva de la presente Ley, directamente o a través de las organizaciones comunitarias, sociales y de la sociedad civil, en general.
e) Asignación y disponibilidad de recursos económicos. El Estado garantiza los recursos suficientes y necesarios para la aplicación efectiva de la presente Ley.
f) Fortalecimiento institucional. Se crean y amplían los mecanismos, normas y políticas de prevención, atención, protección y sanción de hechos de violencia hacia la mujer, incluidos los mecanismos nacionales, departamentales y municipales de adelanto de la mujer o de promoción de sus derechos.
g) Empoderamiento. Se promoverá la independencia de la mujer en situación de violencia respecto a la toma de decisiones y restablecimiento de su dignidad.
h) Tutela efectiva y acceso a la justicia. Se garantizarán las condiciones necesarias para que la mujer en situación de violencia pueda acudir a los servicios de atención y acceso a la justicia, recibiendo una respuesta efectiva y oportuna.
i) Especialización del personal. El Estado dispondrá las medidas necesarias para contar con servidores/as públicos/as con los conocimientos necesarios para garantizar a la mujer en situación de violencia un trato respetuoso, digno y eficaz, en todas las instituciones responsables de la atención, protección y sanción.
j) Atención específica. Asegurar una atención de acuerdo con las necesidades y circunstancias específicas de las mujeres que se encuentren en condiciones de vulnerabilidad o de riesgo frente a la violencia, a fin de garantizar su seguridad y la reparación y/o restitución de sus derechos.
k) Transparencia y Publicidad. Se garantizarán la transparencia y publicidad de todas las actuaciones, planes, programas y proyectos del Estado y sus actores en materia de prevención, atención, investigación, sanción y reparación de la violencia contra las mujeres, garantizando el pleno y permanente conocimiento de la sociedad, previa autorización establecida en el Artículo 11.
l) Servicios competentes. El Estado debe garantizar que los funcionarios públicos que presten servicios en los órganos de atención, investigación y sanción de los hechos de violencia contra las mujeres cumplan con sus deberes y obligaciones y respondan eficazmente a las funciones asignadas en la presente Ley.

Artículo 8º. - Planificación y Presupuestos. Las instituciones públicas con responsabilidades asignadas en la presente Ley, deberán incluir en sus presupuestos

los programas específicos destinados a hacer frente a sus obligaciones en el marco de la presente Ley.
La Ley que aprueba el Presupuesto General de la Nación, debe asignar los recursos presupuestarios necesarios a instituciones, entidades y órganos encargados de la aplicación de la presente Ley.

Artículo 9º. - Confidencialidad. Se garantiza el respeto del derecho a la confidencialidad y a la intimidad, prohibiéndose la reproducción para uso particular o difusión pública de la información relacionada con situaciones de violencia contra la mujer, sin autorización de quien la padece. Salvo en caso de niñas y adolescentes, donde se necesita autorización expresa de los padres o tutores.

CAPÍTULO II
RESPONSABILIDADES ESTATALES PARA LA PREVENCIÓN, ATENCIÓN Y SANCIÓN DE LA VIOLENCIA

Artículo 10. - Políticas. El Estado implementará políticas, estrategias y acciones prioritarias para prevenir, sancionar y erradicar la violencia hacia las mujeres, a través de los distintos organismos y entidades del Estado.

Artículo 11. - Órgano Rector. El Ministerio de la Mujer es el órgano rector encargado del diseño, seguimiento, evaluación de las políticas públicas y estrategias de carácter sectorial e intersectorial para efectivizar las disposiciones de la presente Ley, para ello coordinará acciones con todas las instancias públicas y contará con los recursos necesarios y suficientes del Presupuesto General de la Nación para el cumplimiento de las obligaciones que esta Ley le impone.

Artículo 12. - Ministerio de la Mujer. El Ministerio de la Mujer, en el marco de sus competencias y atribuciones es responsable de:
a) Elaborar, implementar y monitorear un Plan Nacional de Acción para la Prevención, Sanción y Erradicación de la Violencia contra la Mujer que contemple programas articulados interinstitucionales para transformar patrones socioculturales que naturalizan y perpetúan la violencia hacia las mujeres, así como el fortalecimiento de los servicios de atención integral y las medidas de reparación para ellas y sus dependientes.
b) Articular y coordinar las acciones para el cumplimiento de la presente Ley, en particular el fortalecimiento de servicios, la capacitación al funcionariado público y la adopción de protocolos por parte de las distintas instituciones públicas involucradas a nivel nacional, departamental y municipal, incluyendo la participación de redes de mujeres y organizaciones no gubernamentales dedicadas a la defensa y promoción de los derechos de las mujeres, organizaciones de derechos humanos, universidades, sindicatos, empresas y otras de la sociedad.
c) Constituir una Mesa Interinstitucional integrada por instituciones públicas y representantes de organizaciones y redes de la sociedad civil, que tendrá por función asesorar al órgano rector y recomendar estrategias y acciones adecuadas para enfrentar la violencia.

d) Fortalecer los Servicios de Atención a la Mujer, los Centros Regionales de las Mujeres para ampliar su cobertura a nivel nacional, con el propósito de ofrecer atención integral a todas las mujeres en situación de violencia, debiendo incluir asistencia psicológica, legal y social.
e) Brindar apoyo a las gobernaciones en los procesos de creación y desarrollo de los albergues transitorios, a modo de lograr una cobertura a nivel nacional.
f) Desarrollar programas de empoderamiento de las mujeres que respeten la complejidad de la naturaleza social, política y cultural de la problemática, prohibiendo modelos que contemplen formas de mediación, conciliación o negociación.
g) Impulsar a través de los colegios y asociaciones de profesionales la capacitación del personal de los servicios que, en razón de sus actividades, puedan llegar a intervenir en casos de violencia contra las mujeres.
h) Promover campañas de sensibilización, concienciación con el objetivo de modificar los patrones socioculturales de conducta de hombres y mujeres, con miras a eliminar los prejuicios y las prácticas que estén basadas en la idea de la inferioridad o superioridad de cualquiera de los sexos o en funciones estereotipadas, igualmente dirigir programas específicos contra la violencia hacia las mujeres.
i) Difundir la presente Ley tanto en las instituciones públicas como en la sociedad a través de medios escritos, audiovisuales y nuevas tecnologías de la información y comunicación, así como sobre servicios de asistencia directa, públicos y privados, para mujeres en situación de violencia.
j) Desarrollar un sistema de indicadores que permita medir el avance en la implementación de la presente Ley, el desempeño de los servicios públicos.
k) Diseñar e implementar el Sistema Unificado y Concentrado de Registro que permita contar con datos y estadísticas que den cuenta de la realidad nacional en términos de violencia contra las mujeres.
l) Administrar el Fondo de Promoción de Políticas para la Erradicación de la Violencia contra las Mujeres.
m) Todas aquellas medidas que estime convenientes para lograr la prevención, sanción y erradicación de la violencia contra las mujeres.

Artículo 13. - Ministerio de Educación y Cultura. El Ministerio de Educación y Cultura es el órgano responsable de ejecutar las siguientes medidas en el ámbito de prevención y detección de la violencia:
a) Incorporar la perspectiva de igualdad de derechos del hombre y de la mujer, la no discriminación, el respeto a los derechos humanos y la formación en la resolución pacífica de conflictos en la currícula educativa en todos los niveles, incluidas las escuelas superiores de formación docente y técnica, para contribuir a una cultura de respeto en el ámbito familiar, comunitario, escolar, laboral y social, como una práctica diaria.
b) Incluir en los planes de formación y actualización docente la detección precoz de la violencia contra las niñas y mujeres, así como mecanismos y protocolos para el abordaje de la problemática en general y principalmente dentro de las comunidades indígenas.

c) Establecer medidas para la escolarización inmediata de las hijas e hijos de mujeres en situación de violencia que hubiesen tenido que cambiar de residencia por esta causa o que por cualquier otra razón se encuentren en situación de riesgo.
d) Revisar y actualizar los libros de texto y materiales didácticos utilizados en el sistema educativo con la finalidad de fomentar la igualdad de derechos, oportunidades, trato y resultados de las mujeres con relación a los hombres, en general y principalmente en la educación indígena.
e) Establecer sistemas o programas de denuncias en el ámbito educativo, en todos sus niveles, considerando la relación jerárquica que pueda existir entre la víctima y las personas agresoras.
f) Instruir la obligación de los centros educativos de referir al Ministerio Público o la Policía Nacional los casos de violencia de los que tengan conocimiento o hubieren detectado.
g) Velar por que las mujeres indígenas tengan fácil acceso a las escuelas tanto en el ingreso como en la permanencia, garantizando la enseñanza en su lengua materna y bilingüismo, y atendiendo las necesidades especiales de las mujeres de comunidades indígenas monolingües.

Artículo 14. - Secretaría de Información y Comunicación. La Secretaría de Información y Comunicación es responsable de:
a) Establecer desde el Sistema Nacional de Comunicación la difusión de mensajes y campañas permanentes de sensibilización y concienciación dirigidas a la población en general y principalmente a las mujeres sobre el derecho a vivir una vida libre de violencia y a la no discriminación.
b) Sensibilizar sobre la desnaturalización de la violencia hacia las mujeres, el uso no sexista de su imagen, su cosificación y el manejo adecuado de la información sobre hechos de violencia, a los medios masivos de comunicación, agencias de publicidad y anunciantes.
c) Adoptar en coordinación con las organizaciones representativas de los medios de comunicación y trabajadores y trabajadoras de la prensa, directrices para la difusión de información sobre hechos de violencia, así como de programas, mensajes y contenidos para contribuir a prevenir la violencia contra las mujeres en todas sus formas y garantizar el respeto a la dignidad de las mujeres.
d) Brindar capacitación a profesionales de los medios masivos de comunicación en violencia hacia las mujeres y tratamiento informativo.

Artículo 15. - Secretaría de Tecnologías de la Información y Comunicación. La Secretaría Nacional de Tecnología de la Información y Comunicación es responsable de realizar campañas permanentes de sensibilización y concienciación dirigidas a la población en general y principalmente a las mujeres sobre la violencia telemática y medidas de prevención.
Igualmente es función de esta Secretaría desarrollar e implementar protocolos de detección y prevención de las nuevas formas de violencia contra mujeres en el uso de las Tecnologías de la Información y la Comunicación (TIC).

Artículo 16. - Secretaría de la Función Pública. Son obligaciones de la Secretaría de la Función Pública:

a) Establecer políticas específicas para implementar la presente ley en el sistema de administración pública, en especial respecto a la discriminación, el acoso sexual y laboral, la igualdad en el trabajo para hombres y mujeres, así como la implementación de las normas relativas a la responsabilidad del funcionariado público por actos u omisiones que signifiquen actos de violencia hacia las mujeres.
b) Sensibilizar y capacitar al personal de la administración pública desde una perspectiva de igualdad de derechos del hombre y de la mujer, la no discriminación y los derechos humanos de las mujeres, especialmente el derecho a una vida libre de violencia.

Artículo 17. - Ministerio de Trabajo, Empleo y Seguridad Social. El Ministerio de Trabajo, Empleo y Seguridad Social, en el marco de sus atribuciones y funciones deberá:
a) Establecer políticas para la recuperación de las mujeres trabajadoras en situación de violencia y la restitución de sus derechos laborales.
b) Establecer programas de capacitación técnica y productiva para mujeres en situación de violencia y de inserción laboral.
c) Elaborar y poner en práctica criterios para la inclusión de las mujeres en los planes y programas de fortalecimiento y promoción laboral.
d) Ejecutar programas para el empoderamiento social y económico de las mujeres incluido el acceso al crédito, la capacitación profesional y empresarial, así como la reducción de la brecha salarial entre hombres y mujeres.
e) Desarrollar programas de sensibilización y capacitación a empresas y sindicatos para eliminar la violencia laboral contra las mujeres y promover la igualdad de derechos y oportunidades en el ámbito laboral.
f) Establecer mecanismos de vigilancia y sanción del Estado por el incumplimiento de los derechos laborales de la mujer, con prioridad de las que viven en situación de violencia.

Artículo 18. - Secretaría de Acción Social. La Secretaría de Acción Social, en el ejercicio de sus funciones, promoverá las políticas de protección, prevención y eliminación de todas formas de violencia contra la mujer en sus proyectos o programas de protección y promoción e inclusión económica, que apuntan principalmente al empoderamiento social y a la autonomía económica de las mujeres.

Artículo 19. - Secretaría de Emergencia Nacional. La Secretaría de Emergencia Nacional deberá considerar acciones que aseguren que tanto mujeres como hombres reciban por igual los beneficios de las medidas desarrolladas respecto a la gestión y reducción del riesgo.
En los casos en los que la población requiera el albergue en lugares especiales o campamentos, deberá coordinar con las instituciones pertinentes la atención especial a mujeres víctimas de violencia doméstica, a fin de que la misma situación no continúe.

Artículo 20. - Secretaría Nacional de la Vivienda y Hábitat. La Secretaría Nacional de la Vivienda y Hábitat deberá considerar a la mujer afectada a la presente

Ley, con enfoque prioritario para el acceso a viviendas sociales y programas habitacionales, reconociendo las circunstancias y el contexto de desprotección y de vulnerabilidad en el que se encuentran.

Artículo 21. - Secretaría Nacional de la Niñez y la Adolescencia. La Secretaría Nacional de la Niñez y la Adolescencia es responsable de:
a) Elaborar protocolos de atención para las niñas/os y adolescentes que viven en situación de violencia.
b) Elaborar protocolos de atención a niñas y adolescentes que hubiesen sufrido cualquier tipo de violencia, en especial violencia sexual, en conjunto con el Ministerio de la Mujer y el Ministerio de Salud Pública y Bienestar Social.
c) Coadyuvar en la capacitación del personal de los servicios de atención sobre los derechos de la niñez y la adolescencia, la detección de violencia y las directrices para su atención.
d) Informar a las autoridades competentes sobre el conocimiento de hechos de violencia sobre niñas/os y adolescentes de acuerdo con las leyes respectivas.

Artículo 22. - Ministerio de Salud Pública y Bienestar Social. El Ministerio de Salud Pública y Bienestar Social deberá:
a) Diseñar y aplicar protocolos específicos de detección precoz y atención a las mujeres en situación de violencia, en todas las especialidades.
b) Organizar efectivamente la aplicación de un Registro de las personas asistidas por situaciones de violencia contra las mujeres, para los reportes al Sistema Único y Estandarizado de Registro.
c) Dotar de presupuesto suficiente al Programa Nacional de Prevención y Atención de la Violencia, dependiente de la Dirección de Género de la Dirección General de Programas de Salud u otras iniciativas.
d) Crear programas para la atención integral a mujeres en situación de violencia como de sus hijas e hijos.
e) Establecer un sistema de servicio de salud integral en las Casas de Acogida dependientes de las Gobernaciones, las que deberán implementar los lineamientos del programa nacional para la prevención y atención integral de la violencia.
f) Crear programas para la atención psicológica de la persona agresora, a fin de evitar la reincidencia.
g) Otorgar, en forma inmediata, la constancia médica y diagnóstico médico y/o psicológico a las víctimas de violencia que acudan al servicio de salud.
h) Sensibilizar y capacitar al personal de salud y monitorear la función desempeñada por los mismos en torno a los temas de violencia contra las mujeres.
Artículo 23. - Ministerio de Justicia. El Ministerio de Justicia es responsable de implementar las siguientes medidas:
a) Implementar políticas nacionales de derechos humanos contenidas en planes, que guarden relación con la prevención, protección y eliminación de la violencia hacia las mujeres.
b) Elaborar y aplicar medidas de acción para la prevención y protección de la violencia hacia las mujeres.
c) Implementar medidas y acciones que faciliten el acceso a la justicia y a la información de las mujeres.

d) Potenciar las acciones y medidas ejecutadas para garantizar la calidad de vida de las mujeres privadas de libertad.
e) Desarrollar y promocionar programas de reinserción social destinados a mujeres privadas de libertad.
f) Capacitar y empoderar a las mujeres privadas de libertad sobre sus derechos y los mecanismos con que se cuenta para hacer frente a actos de violencia perpetrados contra las mismas en el sistema penitenciario.
g) Establecer protocolos de tratamiento especializado para mujeres pertenecientes a grupos en condición de vulnerabilidad en la que se encuentran privadas de libertad.
h) Garantizar el acceso a los servicios de atención específica para mujeres privadas de libertad y sus hijos e hijas.
i) Fortalecer las dependencias institucionales que intervienen en la ejecución de acciones en favor de las mujeres.

Artículo 24. - Consejerías Municipales por los Derechos del Niño, la Niña y el Adolescente. Las Consejerías Municipales por los Derechos del Niño, la Niña y el Adolescente son responsables de:
a) Contar con mecanismos de información sobre los derechos y los recursos disponibles frente a los actos de violencia descriptos en la presente Ley.
b) Informar a la autoridad judicial o al Juzgado de la Niñez y la Adolescencia, la Defensoría de la Niñez y la Adolescencia, y Fiscalía, sobre hechos de violencia hacia niñas y adolescentes mujeres de los cuales tenga conocimiento de acuerdo con las leyes vigentes.
En ningún caso, las Consejerías podrán mediar o conciliar los hechos de violencia que lleguen a su conocimiento, debiendo remitir las actuaciones a los órganos pertinentes velando en todo momento por la integridad física de la mujer y sus dependientes.

Artículo 25. - Municipalidades. Los Gobiernos municipales a través de la intendencia y las juntas municipales y con el apoyo técnico del Ministerio de la Mujer crearán Servicios Integrales de Prevención y Atención a Mujeres en Situación de Violencia, las que tendrán por funciones:
a) Realizar campañas de sensibilización, difusión y capacitación orientadas a la comunidad para informar, concienciar y prevenir la violencia contra las mujeres en los ámbitos en los que se desarrollen sus relaciones interpersonales.
b) Brindar asistencia y orientación psicológica y jurídica gratuita, a las mujeres en situación de violencia.
c) Habilitar una línea telefónica de información y orientación a mujeres en situación de violencia y coordinar con la Policía Nacional acciones en los casos que requieran auxilio inmediato.
d) Llevar un registro de casos para reportar información al Sistema Único y Estandarizado de Registro y adoptar un protocolo de atención.
e) Impulsar políticas municipales integrales de prevención de la violencia.

Artículo 26. - Gobernaciones. Las Gobernaciones son responsables de crear Casas de Acogida para mujeres en situación de violencia en sus respectivos

departamentos, coordinando con enfoque interdisciplinario, los servicios de asistencia médica, psicológica, legal, laboral y social con el Ministerio de la Mujer, el Ministerio de Salud Pública y Bienestar Social, el Ministerio del Trabajo u otras dependencias, según corresponda.

CAPÍTULO III
Políticas ESTATALES PARA LA PREVENCIÓN, ATENCIÓN Y PROTECCIÓN PARA LAS MUJERES víctimas DE VIOLENCIA

Artículo 27. - Mesa Interinstitucional de Prevención de la Violencia contra la Mujer.
La Mesa Interinstitucional de Prevención de la Violencia contra la Mujer es coordinada por el Ministerio de la Mujer e integrada por una representación de cada una de las siguientes instituciones:
a) Ministerio de la Mujer;
b) Ministerio del Interior;
c) Ministerio de Hacienda;
d) Ministerio de Salud Pública y Bienestar Social;
e) Ministerio de Educación y Cultura;
f) Ministerio de Justicia;
g) Ministerio de Trabajo, Empleo y Seguridad Social;
h) Secretaría Nacional de la Niñez y la Adolescencia;
i) Dirección General de Estadística, Encuestas y Censos, dependiente de la Secretaría Técnica de Planificación del Desarrollo Económico y Social;
j) Secretaría de Acción Social;
k) Secretaría de Emergencia Nacional;
l) Secretaría de Información y Comunicación de la Presidencia de la República;
m) La Secretaría Nacional de Tecnología de la Información y Comunicación;
n) Ministerio Público;
ñ) Ministerio de la Defensa Pública;
o) Secretaría Nacional por los Derechos de las Personas con Discapacidad;
p) Poder Judicial;
q) Comisiones de Equidad de Género y de Derechos Humanos de las Cámaras de Diputados y Senadores del Congreso Nacional; y,
r) Sociedad Civil, representantes de al menos 5 (cinco) organizaciones.
Constituida la Mesa Interinstitucional, debe elaborar y aprobar su reglamento interno.

Artículo 28. - Casas de Acogida. Créase el programa de Casas de Acogida, que deberá ser implementado y estará a cargo de las Gobernaciones Departamentales bajo la coordinación general, supervisión y apoyo técnico del Ministerio de la Mujer. Los servicios brindados por las Casas de Acogida deben realizarse en coordinación con las demás entidades públicas responsables, conforme la presente Ley y tienen como objetivo:
a) Proteger a la mujer y su grupo familiar afectado que se encuentre en riesgo y desprotección generada por situaciones de violencia, sea que lleguen por su propia

cuenta o derivadas de instituciones públicas u organismos no gubernamentales.
b) Asegurar el apoyo inmediato, la integridad física, emocional y la atención psicosocial a la víctima y sus dependientes, si así lo requiera el caso.
c) Prestar asistencia interdisciplinaria psicológica, social, legal y, en su caso, médica, coordinando con las unidades policiales, fiscalía y juzgados correspondientes las medidas de protección que deban ser tomadas de manera inmediata.
d) Brindar información a la mujer víctima de violencia sobre los derechos que le asisten y acompañar y facilitar el acceso a capacitación laboral, empleo, vivienda, programas sociales y demás derechos establecidos en la presente Ley.
e) Ofrecer albergue transitorio a la mujer en situación de violencia y sus dependientes que se encuentran en riesgo cuando estas no puedan obtener un sustento económico, y mientras que se mantenga el estado de peligro.
f) Ofrecer capacitación laboral y académica a las mujeres en situación de violencia, sea en las instalaciones del centro de acogida o en otras instituciones.
g) Organizar en coordinación con las organizaciones de la sociedad civil una bolsa de empleos del sector privado para ayudar a que las mujeres en situación de violencia accedan a un trabajo digno; y,
h) Todos los servicios que puedan cooperar en el restablecimiento de las mujeres en situación de violencia y su grupo familiar o dependiente.

Artículo 29. - Sistema Unificado y Estandarizado de Registro. El Ministerio de la Mujer creará el Sistema Unificado y Estandarizado de Registro de Violencia contra las Mujeres, en coordinación con la Dirección General de Estadística, Encuestas y Censos.
El Estado es responsable de la recopilación y sistematización de datos que incluyan toda información sobre las causas, consecuencias y frecuencia de la violencia, con el fin de evaluar la eficacia de las medidas para prevenir, sancionar y erradicar la violencia contra las mujeres, y de formular, monitorear y evaluar las políticas públicas pertinentes.
El Poder Judicial, el Ministerio Público, el Ministerio del Interior, la Policía Nacional, el Ministerio de la Defensa Pública, el Ministerio de Salud Pública y Bienestar Social, el Ministerio de Educación y Cultura, la Secretaría Nacional de la Niñez y la Adolescencia, el Ministerio de Justicia, el Ministerio de Trabajo, Empleo y Seguridad Social, Secretaría Nacional por los Derechos de las Personas con Discapacidad y la Secretaría de la Función Pública reportarán información sobre todos los casos atendidos al Sistema Único y Estandarizado de Registro, con base en los criterios definidos con el Ministerio de la Mujer para cada institución y garantizaran mecanismos de acceso público a la información generada a la sociedad civil.

Artículo 30. - Informes del Sistema. Los informes producidos por el Sistema Único y Estandarizado de Registro deben contener:
a) Identificación y cantidad de mujeres denunciantes por edad, discapacidad, estado civil, procedencia territorial, lengua, etnia, escolaridad, profesión u ocupación, vínculo con la persona agresora, naturaleza de los hechos, y su cuantificación.

b) Cuantificación de las personas agresoras por procedencia territorial, edad, ocupación, origen étnico, estado civil, escolaridad, profesión u ocupación.
c) Datos de los hechos de violencia atendidos, incluyendo tipos de la violencia contra la mujer y conductas punibles.
d) Datos del proceso judicial que incluyan por lo menos la duración de las etapas procesales, las medidas cautelares y las de protección ordenadas, los requerimientos conclusivos y las sentencias.
e) Los recursos y origen de los presupuestos erogados para la atención de las mujeres víctimas de violencia.
El Ministerio de la Mujer publicará y difundirá por diversos medios y de forma anual las estadísticas de violencia contra las mujeres y el monitoreo de la implementación de esta ley, los cuales deben estar disponibles a solicitud de cualquier persona física o jurídica que así lo requiera.

Artículo 31. - Observatorio de Derecho de las Mujeres a una Vida Libre de Violencia. El Ministerio de la Mujer creará el Observatorio de Derecho a las Mujeres a una Vida Libre de Violencia, destinado al monitoreo e investigación sobre la violencia contra las mujeres, a los efectos de diseñar políticas públicas para la prevención y erradicación de la violencia contra las mujeres.
El Observatorio tendrá los siguientes deberes:
1. Generar una red de información interinstitucional con todos los servicios de atención y protección a las mujeres en situación de violencia pública o privada;
2. Establecer relaciones con otros Observatorios y redes sobre violencia hacia las mujeres;
3. Realizar estudios e investigaciones sobre la violencia contra las mujeres en coordinación con instituciones públicas y organizaciones no gubernamentales; y,
4. Presentar informes periódicos al Ministerio de la Mujer.

Artículo 32. - Servicios Integrales de Prevención y Atención. El Estado, mediante la rectoría del Ministerio de la Mujer promoverá en las distintas jurisdicciones y niveles descentralizados la creación y/o fortalecimiento de los servicios integrales especializados de atención a la mujer en situación de violencia y a las personas que la ejercen.
El Sistema de Prevención y Atención está integrado por todos los servicios públicos dependientes del Poder Ejecutivo, Municipalidades y Gobiernos Departamentales, y coordinará acciones con los servicios de organizaciones no gubernamentales, universidades y otros que trabajen en la prevención de la violencia hacia las mujeres y ofrezcan servicios gratuitos.
Los servicios de prevención y atención integral son responsables de:
a) Difundir la presente Ley y los servicios integrales que brindan a las mujeres en situación de violencia.
b) Capacitar de manera permanente a su personal para la aplicación de la presente Ley.
c) Adoptar las medidas necesarias en cuanto a infraestructura, equipamiento y recursos humanos.
d) Elaborar y aplicar protocolos específicos para regular y uniformar su accionar evitando la revictimización, sin perjuicio de la adecuación de los protocolos de

atención e intervención actualmente vigentes, así como el seguimiento y evaluación de su cumplimiento.
Todo servicio de atención deberá ser extensivo a las hijas e hijos de la mujer en situación de violencia y a otras personas dependientes en condiciones de riesgo.

Artículo 33. - Servicios Nacionales. El Ministerio de la Mujer ampliará la cobertura de los Servicios de Atención a la Mujer, de los Centros Regionales de la Mujer y coordinará con las Gobernaciones Departamentales la creación de las Casas de Acogida. Estos servicios deberán ofrecer atención integral e interdisciplinaria a la mujer en situación de violencia, la que incluirá asistencia médica, psicológica, legal, laboral y social, para lo que podrá suscribir acuerdos intergubernamentales con Municipalidades y Gobernaciones Departamentales.
El Ministerio del Trabajo, Empleo y Seguridad Social creará servicios de atención, orientación y referencia para trabajadoras en situación de violencia y coordinará con las Casas de Acogida la incorporación de mujeres a los programas de capacitación y empleo.
El Estado promoverá a organizaciones de la sociedad civil que brinden estos servicios.

Artículo 34. - Reeducación de la Persona Agresora. El Estado, a través del Ministerio de Salud Pública y Bienestar Social y del Ministerio de la Mujer, establecerá mecanismos y servicios dirigidos a la reeducación de la persona agresora, que podrán ser utilizados en forma voluntaria o por orden del Juzgado interviniente, observando las siguientes premisas:
a) Contar con programas de intervención conductual y educación psicosocial para personas que hayan incurrido en hechos de violencia contra la mujer.
b) Coordinar entre los prestadores de servicios a personas agredidas y agresores, evitando el encuentro de la víctima y la persona agresora.
c) Crear programas y espacios para la ejecución de trabajo comunitario en caso de que sea ordenado por el Juzgado interviniente.
d) Proveer terapia psicológica para las personas agresoras que lo precisen, en los servicios sociales habilitados, sean estos de carácter público o privado.
e) Proveer información actualizada y periódica sobre el diagnóstico, el tratamiento, la reeducación y sus avances, al Juzgado Penal de Ejecución.

Artículo 35. - Medios de comunicación. Los medios de comunicación social deberán garantizar el respeto a la dignidad e intimidad de las mujeres en situación de violencia y sus hijos, hijas y dependientes en la difusión de informaciones relativas a los hechos de violencia.

CAPÍTULO IV
SISTEMA ESTATAL DE PROTECCIÓN A LA MUJER ANTE HECHOS DE VIOLENCIA

Artículo 36. - Poder Judicial. El Poder Judicial, a través del órgano correspondiente, incorporará la perspectiva de igualdad de derechos entre el hombre y la mujer en

sus políticas internas y en la administración de justicia, para el conocimiento y juzgamiento de las causas que involucren hechos relacionados con la violencia hacia las mujeres.
Para la adecuada implementación de la presente Ley y el cumplimiento de sus fines, el Poder Judicial deberá:
a) Designar personal capacitado, eficiente y suficiente para cumplir las funciones relativas al conocimiento y juzgamiento de hechos de violencia.
b) Dotar de la infraestructura necesaria para la atención de la mujer en situación de violencia, acorde a los principios de celeridad, privacidad, oficiosidad, gratuidad y otros previstos en esta Ley.
c) Adoptar todas las medidas necesarias para asegurar el acceso a la justicia a las mujeres en situación de violencia, una respuesta efectiva del sistema judicial y el respeto a sus derechos y garantías.
d) Fortalecer el marco procesal vigente, a través de acordadas y protocolos de atención para asegurar una protección integral a las mujeres víctima de violencia en las instancias jurisdiccionales.
e) Diseñar y ejecutar planes, programas y proyectos de capacitación en derechos humanos, derechos humanos de las mujeres, dirigidos a las/os funcionarias/os de la administración de justicia que intervengan en el tratamiento de los hechos que contempla esta ley. La sensibilización, capacitación y formación se coordinará con el Ministerio de la Mujer, pudiendo suscribir convenios con las áreas de estudios de la mujer en las universidades.
f) Crear una base de datos con información sobre todas las denuncias por hechos de violencia contra las mujeres ingresados en el sistema judicial y reportar los mismos al Sistema Unificado y Estandarizado de Registro.
g) Realizar estudios e investigaciones en la materia.

Artículo 37. - Juzgados de Paz. Los Juzgados de Paz, además de las facultades que les confiere la Ley, son competentes para:
a) Recibir denuncias sobre hechos de violencia contra las mujeres y disponer medidas de protección para la preservación de la vida, la integridad de la mujer, sus bienes y derechos, establecidas en la presente Ley, aplicando el procedimiento previsto en la Ley Nº 1600/00 "Contra la Violencia Doméstica" y en el caso de ser niñas y/o adolescentes mujeres actuar conforme las disposiciones de la Ley N° 4295/11 "Que establece el procedimiento especial para el tratamiento del maltrato infantil en la jurisdicción especializada", de conformidad con lo dispuesto en el Artículo 40 de esta Ley.
b) La substanciación y la resolución del procedimiento abreviado por hechos punibles de violencia hacia las mujeres conforme lo previsto en el Artículo 44 del Código Procesal Penal.
c) Remitir compulsas de las actuaciones a la Unidad Fiscal que corresponda, en la brevedad posible, a fin de que se inicie y prosiga el proceso penal que corresponda.
d) Remitir compulsas de las actuaciones a la Unidad Fiscal que corresponda, en el plazo de 24 (veinticuatro) horas, a fin de que se inicie y prosiga el proceso penal que corresponda cuando de las actuaciones se desprenda la comisión de un hecho punible.

Artículo 38. - Ministerio de la Defensa Pública. El Ministerio de Defensa Pública deberá prestar asistencia jurídica y patrocinio legal a las mujeres en situación de violencia sin necesidad de realizar el beneficio de litigar sin gastos, debiendo llevar un registro de todos los casos de violencia y reportarlos al Sistema Unificado y Estandarizado de Registro.

Artículo 39. - Ministerio Público. A los fines de esta Ley y, sin perjuicio de sus demás obligaciones y facultades, el Ministerio Público debe:
a) Asignar los recursos necesarios e infraestructura adecuada para la investigación y persecución de los hechos punibles de violencia contra la mujer. Para ello deberá capacitar y especializar a su personal. Podrá crear Unidades Especializadas, sin perjuicio de que todas las Unidades Fiscales Penales estén obligadas a recibir denuncias y en su caso, persigan tales hechos.
b) Iniciar y proseguir la investigación, ejerciendo la acción penal a través de los/as agentes fiscales.
c) Capacitar a los/as agentes fiscales, asistentes fiscales y funcionariado, personal contratado y del servicio auxiliar en general, en materia de violencia hacia las mujeres.
d) Prever la designación de personal capacitado, eficiente y suficiente en todos los cargos en los cuales se cumplan funciones relacionadas con la investigación y persecución de los hechos punibles de violencia contra las mujeres.
e) Adoptar protocolos de atención e investigación de casos de violencia contra las mujeres que consideren circunstancias especiales para casos en los cuales la víctima se encuentre en situación de crisis, requiera atención médica inmediata o se trate de delitos sexuales, entre otros que requieren atención diferenciada.
f) Establecer los criterios de actuación y de persecución penal en hechos punibles de violencia contra las mujeres.
g) Crear una base de datos para el registro de las denuncias y estado de los procesos a efecto de reportar esta información al Sistema Unificado y Estandarizado de Registro.
h) Aplicar las sanciones administrativas disciplinarias pertinentes, sobre cuyo dictado tenga competencia, a agentes fiscales, asistentes fiscales, personas pertenecientes a su funcionariado, su personal contratado y del servicio auxiliar, en caso de incumplimiento de los deberes y obligaciones establecidas en esta Ley, o de deficiente ejercicio de las facultades conferidas en ella.

Artículo 40. - Policía Nacional. 1. La Policía Nacional, en el marco de sus atribuciones deberá adoptar las siguientes medidas:
a) Crear y fortalecer las Divisiones Especializadas para la atención de hechos punibles de violencia contra las mujeres, sin perjuicio que todo el personal policial, especializado o no, pueda intervenir en los casos de violencia contra las mujeres cuando fuere necesario.
b) Dotar de la infraestructura y recursos suficientes para la intervención policial en hechos de violencia hacia las mujeres en todo el país.
c) Prever mayor designación de personal capacitado, eficiente y suficiente en todos los cargos en los cuales se cumplan funciones relacionadas con la atención de los hechos de violencia contra las mujeres.

d) Difundir los protocolos de atención e investigación en coordinación con el Ministerio de la Mujer, a fin de brindar las respuestas adecuadas y evitar la revictimización de las mujeres en situación de violencia, atendiéndolas con diligencia.
e) Fortalecer todas las comisarias para la atención de hechos de violencia contra las mujeres en sus distintos ámbitos, a fin de garantizar el auxilio y socorro en los casos en los que requieran protección inmediata, para lo que contarán con el personal suficiente, los medios de transporte y líneas gratuitas. En los lugares donde no existan unidades policiales especializadas y cuando fuere necesaria la atención a las víctimas debe ser prestada por las autoridades policiales ordinarias.
f) Llevar un registro de denuncias y estadísticas desagregadas para el reporte al Sistema Único y Estandarizado de Registro.
2. Todos los funcionarios de la Policía Nacional y de las Unidades o Comisarías Especializadas para la atención de la violencia contra la mujer, deberán:
a) Recibir en forma inmediata las denuncias sobre hechos de violencia, garantizar la integridad física de la denunciante y sus dependientes y remitir el caso con todos los informes pertinentes al juzgado competente y al Ministerio Público.
b) Presentar el informe oficial al Ministerio Público sobre las actuaciones de la denuncia dentro de las seis horas contadas desde el inicio de la intervención.
c) Informar sobre anteriores denuncias formuladas contra la misma persona agresora.
d) Proporcionar protección efectiva en el traslado de la mujer agredida y a la persona denunciante de la violencia.
e) Realizar el seguimiento a la situación de las mujeres que hubieren denunciado hechos de violencia, en especial cuando se hubieren dictado medidas de protección, mediante visitas domiciliarias u otras verificaciones adecuadas debiendo informar al Juez de Paz cuando se hayan tomado medidas de protección, conforme la Ley Nº 1600/00 "Contra la Violencia Doméstica" y al Ministerio Público, en su caso.
f) Constatar la existencia de armas de cualquier tipo en el lugar de los hechos o en posesión de la persona agresora.
g) Efectuar detenciones en casos de flagrancia, pudiendo ingresar a recintos públicos o privados sin necesidad de orden judicial, de forma excepcional, cuando existan elementos fehacientes que hagan presumir la comisión de hechos punibles de violencia contra la vida o la integridad física de la mujer y sus hijos e hijas o adultos mayores a su cargo.

Artículo 41. - Sanciones. Los funcionarios públicos son pasibles de sanciones administrativas disciplinarias en caso de incumplimiento de los deberes y obligaciones establecidos en esta Ley.

CAPÍTULO V
MEDIDAS DE PROTECCIÓN

Artículo 42. - Finalidad. Las medidas de protección tienen por finalidad detener los actos de violencia feminicida, física, psicológica o sexual y proteger a la mujer agredida y a los miembros de su entorno familiar como hijos, hijas o personas dependientes en su integridad física, psicológica, sexual y patrimonial.

Artículo 43. - Medidas de protección. Las medidas de protección, sin perjuicio de lo establecido en la Ley N° 1600/00 "Contra la Violencia Doméstica" son las siguientes:
a) Ordenar en los casos de violencia entre cónyuges, convivientes o parejas sentimentales aunque se traten de relaciones vigentes o finalizadas que la persona denunciada se mantenga a una distancia determinada mínima de la mujer en situación de violencia, sus hijos e hijas o de otras personas vinculadas a ella, así como su vivienda, o cualquier otro espacio donde acontezca la violencia. Cuando la persona denunciada y la victima trabajen o estudien en el mismo lugar, se ordenará esta medida adecuándola para garantizar la integridad de la mujer; sin que se vean afectados los derechos laborales de la misma.
b) Prohibir a la persona denunciada que, de manera directa o indirecta, realice actos de persecución, intimidación o acoso a la mujer agredida o algún integrante de su familia o dependientes.
c) En caso de violencia contra niñas y adolescentes mujeres los Juzgados de Paz deberán tomar las medidas comprendidas en esta Ley o cualquiera de las medidas de protección urgentes previstas en el Código de la Niñez y la Adolescencia y remitir las actuaciones al Juzgado de la Niñez y la Adolescencia dentro de las 48 (cuarenta y ocho) horas.
d) Disponer la custodia policial en el lugar donde se encuentre la mujer agredida por el tiempo que se considere conveniente.
e) Disponer el inventario de los bienes de la comunidad conyugal o los comunes de la pareja, y de los bienes propios de la mujer en situación de violencia, de la sociedad comercial o cualquier otro bien que compartan la mujer y la persona denunciada.
f) Emitir una orden judicial de protección y auxilio a favor de la denunciante. La víctima portará copia de esta orden para que pueda acudir a la autoridad más cercana en caso de amenaza de agresión fuera o dentro de su domicilio.
g) Adoptar cualquier otra medida que se considere necesaria.
El Juzgado Penal de Garantías o de Paz que tenga a su cargo resolver la solicitud de implementación de medidas de protección, comunicará a la autoridad policial competente más cercana la medida a ser implementada.
La resolución que ordene medidas de protección, apercibirá a las partes que incurrirán en el hecho punible de desacato en caso de incumplimiento de una o varias de las medidas dictadas.

Artículo 44. - Prohibición de conciliación o mediación. Se prohíbe aplicar la conciliación, mediación o arbitraje o cualquier otro medio de resolución alternativa de conflictos de hechos de violencia hacia la mujer, antes y durante la tramitación del procedimiento de medidas de protección.

Artículo 45. - Medidas de seguimiento. Una vez dictada la resolución judicial que establezca medidas de protección, el juzgado competente podrá ordenar medidas tendientes a asegurar su cumplimiento, consistentes en:
a) Requerir informe sucesivo de evaluación de riesgo y situación psicosocial de la mujer víctima de violencia.

b) Requerir informe sucesivo de evaluación psicosocial de la persona agresora.
c) Ordenar que la persona agresora se presente periódicamente ante el Juzgado, a fin de determinar el grado de ejecución de la medida de protección dispuesta.
d) Disponer que la persona agresora comunique al Juzgado cualquier cambio de domicilio personal y laboral.
e) Disponer que la persona agresora comunique al Juzgado cualquier cambio en su estado patrimonial o de ingresos económicos que afecte a la mujer víctima de violencia.

CAPÍTULO VI
PROCEDIMIENTO PARA DENUNCIA DE HECHOS DE VIOLENCIA HACIA LAS MUJERES

Artículo 46. - Principios Procesales. a) Verosimilitud. Para el dictado de medidas cautelares y de protección personal, en caso de duda, se debe estar a lo manifestado por la victima de los hechos de violencia.
b) Celeridad. Los procedimientos deben ser ágiles y oportunos, considerando la situación de las mujeres en situación de violencia y el riesgo al que se encuentran expuestas, debiendo decretarse las medidas de protección previstas en esta Ley u otras leyes vigentes de manera urgente.
c) Reserva. Las actuaciones relativas a hechos de violencia son reservadas. Solo pueden ser exhibidas u otorgarse testimonio o certificado de las mismas, a solicitud de parte legitimada o por orden de autoridad competente.
d) Deber de informar. Las autoridades, el funcionariado, el personal contratado, el servicio auxiliar en general de la función pública y los particulares que presten servicio público, intervinientes en procedimientos que involucren hechos de violencia, tienen la obligación de informar a la mujer en situación de violencia en el idioma, lenguaje o dialecto que comprenda, en forma accesible a su edad y madurez, los derechos que les asisten, los recursos disponibles, la forma de preservar las evidencias, el estado de los procedimientos judiciales en los que esté involucrada así como copia gratuita de los mismos, y la lista de servicios gubernamentales o no gubernamentales disponibles para su atención.
e) Debida diligencia. Las autoridades competentes deben actuar con probidad y agilidad para prevenir, investigar y enjuiciar los hechos de violencia contra las mujeres. La omisión de la debida diligencia acarrea la aplicación de sanciones. Las mujeres deberán ser atendidas por personas expertas y capacitadas en derechos humanos, derechos de las mujeres y derechos de las víctimas en lugares accesibles que garanticen la privacidad, seguridad y comodidad. Durante la declaración de la mujer, se deberá tener en cuenta su estado emocional y que su declaración sea tomada de manera individual. Durante el proceso, el Juzgado podrá designar un profesional de trabajo social que acompañe el cumplimiento de las medidas de protección y asista a la víctima.
Por ningún motivo, se podrá solicitar a la mujer en situación de violencia realizar actuaciones, citaciones, notificaciones u otras diligencias que sean responsabilidad de funcionarios del sistema de atención o del sistema de justicia, en especial si ellas implican cualquier tipo de contacto o comunicación con la persona agresora o sus familiares.

Artículo 47. - Presentación de la denuncia. La denuncia puede ser presentada ante la Policía Nacional o los Juzgados de Paz sin necesidad de contar con patrocinio o representación letrada, en forma oral o escrita, para la inmediata aplicación de medidas de protección. En ningún caso, se rechazará la recepción de la denuncia.

Artículo 48. - Procedimiento aplicable. El procedimiento para la adopción de medidas de protección ante el Juzgado de Paz será el establecido en la Ley N° 1600/00 "Contra la Violencia Doméstica", así como los recursos aplicables. En caso de niños o adolescentes víctimas, se aplicarán las disposiciones de la Ley N° 4295/11 "Que establece el procedimiento especial para el tratamiento del maltrato infantil en la jurisdicción especializada", conforme a lo estipulado en el Artículo 41 de esta Ley.
Los Juzgados de Paz que reciban la denuncia aplicarán las medidas de protección de manera inmediata y las actuaciones, que se realicen en el marco de este procedimiento, están exentas de todo tributo, tasa, viático o cánon.

CAPÍTULO VII
HECHOS PUNIBLES DE VIOLENCIA HACIA LAS MUJERES

Artículo 49. - Acción Penal Pública. Los hechos punibles tipificados en esta Ley son de Acción Penal Pública.

Artículo 50. - Feminicidio. El que matara a una mujer por su condición de tal y bajo cualquiera de las siguientes circunstancias, será castigado con pena privativa de libertad de diez a treinta años, cuando:
a) El autor mantenga o hubiere mantenido con la víctima una relación conyugal, de convivencia, pareja, noviazgo o afectividad en cualquier tiempo;
b) Exista un vínculo de parentesco entre la víctima y el autor, dentro del cuarto grado de consanguinidad y segundo de afinidad;
c) La muerte ocurra como resultado de haberse cometido con anterioridad un ciclo de violencia física, sexual, psicológica o patrimonial contra la víctima, independientemente de que los hechos hayan sido denunciados o no;
d) La víctima se hubiere encontrado en una situación de subordinación o dependencia respecto del autor, o este se hubiere aprovechado de la situación de vulnerabilidad física o psíquica de la víctima para cometer el hecho;
e) Con anterioridad el autor haya cometido contra la víctima hechos punibles contra la autonomía sexual; o,
f) El hecho haya sido motivado por la negación de la víctima a establecer o restablecer una relación de pareja permanente o casual.

CAPÍTULO VIII
DISPOSICIONES FINALES

Artículo 51. - Vigencia. La presente Ley entrará en vigencia 1 (un) año después de su publicación salvo el Artículo 50 que se aplicará al día siguiente de su publicación.

Artículo 52. - Derogación de Disposiciones Contrarias. Quedan derogadas todas aquellas disposiciones que contradigan a las contenidas en la presente Ley.

Artículo 53. - Vigencia de la Ley Nº 1600/00 "Contra la Violencia Doméstica" y Código Penal. La presente Ley no deroga ni modifica lo dispuesto en la Ley Nº 1600/00 "Contra la Violencia Doméstica", que mantiene su vigencia, así como los tipos penales establecidos en el Código Penal.

Artículo 54. - Reglamentación. El Poder Ejecutivo reglamentará está Ley a los 90 (noventa) días de su publicación.

Artículo 55. - Comuníquese al Poder Ejecutivo.
Aprobado el Proyecto de Ley por la Honorable Cámara de Senadores, a diecisiete días del mes de noviembre del año dos mil dieciséis, quedando sancionado el mismo por la Honorable Cámara de Diputados, a seis días del mes de diciembre del año dos mil dieciséis, de conformidad con lo dispuesto en el Artículo 207 numeral 1) de la Constitución Nacional.

Brasil

LEI Nº 14.737, DE 27 DE NOVEMBRO DE 2023

Altera a Lei nº 8.080, de 19 de setembro de 1990 (Lei Orgânica da Saúde), para ampliar o direito da mulher de ter acompanhante nos atendimentos realizados em serviços de saúde públicos e privados.

O PRESIDENTE DA REPÚBLICA Faço saber que o Congresso Nacional decreta e eu sanciono a seguinte Lei:

Art. 1º O Capítulo VII do Título II da Lei nº 8.080, de 19 de setembro de 1990 (Lei Orgânica da Saúde), passa a vigorar com a seguinte redação:

"'CAPÍTULO VII
DO SUBSISTEMA DE ACOMPANHAMENTO À MULHER NOS SERVIÇOS DE SAÚDE'

'Art. 19-J. Em consultas, exames e procedimentos realizados em unidades de saúde públicas ou privadas, toda mulher tem o direito de fazer-se acompanhar por pessoa maior de idade, durante todo o período do atendimento, independentemente de notificação prévia.
§ 1º O acompanhante de que trata o **caput** deste artigo será de livre indicação da paciente ou, nos casos em que ela esteja impossibilitada de manifestar sua vontade,

de seu representante legal, e estará obrigado a preservar o sigilo das informações de saúde de que tiver conhecimento em razão do acompanhamento.
§ 2º No caso de atendimento que envolva qualquer tipo de sedação ou rebaixamento do nível de consciência, caso a paciente não indique acompanhante, a unidade de saúde responsável pelo atendimento indicará pessoa para acompanhá-la, preferencialmente profissional de saúde do sexo feminino, sem custo adicional para a paciente, que poderá recusar o nome indicado e solicitar a indicação de outro, independentemente de justificativa, registrando-se o nome escolhido no documento gerado durante o atendimento.
§ 2º-A Em caso de atendimento com sedação, a eventual renúncia da paciente ao direito previsto neste artigo deverá ser feita por escrito, após o esclarecimento dos seus direitos, com no mínimo 24 (vinte e quatro) horas de antecedência, assinada por ela e arquivada em seu prontuário.
§ 3º As unidades de saúde de todo o País ficam obrigadas a manter, em local visível de suas dependências, aviso que informe sobre o direito estabelecido neste artigo.
§ 4º No caso de atendimento realizado em centro cirúrgico ou unidade de terapia intensiva com restrições relacionadas à segurança ou à saúde dos pacientes, devidamente justificadas pelo corpo clínico, somente será admitido acompanhante que seja profissional de saúde.
§ 5º Em casos de urgência e emergência, os profissionais de saúde ficam autorizados a agir na proteção e defesa da saúde e da vida da paciente, ainda que na ausência do acompanhante requerido.' (NR)

Portugal

ASSEMBLEIA DA REPÚBLICA
Lei nº 33/2025, de 31 de março

Sumário: Promove os direitos na gravidez e no parto e altera a Lei nº 15/2014, de 21 de março.
Promove os direitos na gravidez e no parto e altera a Lei n.º 15/2014, de 21 de março A Assembleia da República decreta, nos termos da alínea c) do artigo 161.º da Constituição, o seguinte:

Artigo 1.º
Objeto
A presente lei visa promover os direitos na preconceção, na procriação medicamente assistida, na gravidez, no parto, no nascimento e no puerpério, através da criação de medidas de informação e proteção contra a violência obstétrica e da criação da Comissão Multidisciplinar para os Direitos na Gravidez e no Parto, e procede à alteração à Lei n. º 15/2014, de 21 de março, que consolida a legislação em matéria de direitos e deveres do utente dos serviços de saúde.

Artigo 2.º
Violência obstétrica
A violência obstétrica é a ação física e verbal exercida pelos profissionais de saúde sobre o corpo e os procedimentos na área reprodutiva das mulheres ou de outras

pessoas gestantes, que se expressa num tratamento desumanizado, num abuso da medicalização ou na patologização dos processos naturais, desrespeitando o regime de proteção na preconceção, na procriação medicamente assistida, na gravidez, no parto, no nascimento e no puerpério previsto na secção II do capítulo III da Lei n.º 15/2014, de 21 de março.

Artigo 3.º
Educação sexual
O Governo, através do Ministério da Educação, é responsável por incluir informação sobre violência obstétrica nos conteúdos da educação sexual, promovendo o respeito pela autonomia sexual e reprodutiva e a eliminação da violência de género, de forma adequada aos diferentes níveis de ensino, nos termos da Lei n.º 60/2009, de 6 de agosto.

Artigo 4.º
Formação de profissionais de saúde
1 – As instituições de ensino superior relacionadas com a formação em saúde e políticas sociais são responsáveis por incluir conteúdos curriculares e formativos sobre direitos humanos, que assegurem o respeito pela autonomia sexual e reprodutiva e a sensibilização contra as práticas que configuram violência obstétrica.
2 – Na formação de profissionais de saúde, estes aspetos devem ser complementados pelo enriquecimento curricular para uma prática dissuasora de atos de violência obstétrica. 2/4 Lei n.º 33/2025 31-03-2025 N.º 63 1.ª série

Artigo 5.º
Alteração à Lei n.º 15/2014, de 21 de março
O artigo 15.º-E da Lei n.º 15/2014, de 21 de março, passa a ter a seguinte redação:
«Artigo 15.º-E Prestação de cuidados para a elaboração e implementação do plano de nascimento 1 – [...]
2 – [...]
3 – [...]
4 – [...]
5 – [...]
6 – [...]
7 – [...]
8 – Os desvios em relação ao plano de nascimento são obrigatoriamente registados e justificados pelos profissionais de saúde.»

Artigo 6.º
Aditamento à Lei n.º 15/2014, de 21 de março
É aditado à Lei n.º 15/2014, de 21 de março, o artigo 18.º-A, com a seguinte redação:

«Artigo 18.º-A
Informação sobre direitos e prevenção da violência obstétrica
1 – Todos os estabelecimentos de saúde que prestam atendimento ao parto e nascimento têm obrigatoriamente de afixar cartazes com informações sobre o

regime de proteção na preconceção, na procriação medicamente assistida, na gravidez, no parto, no nascimento e no puerpério.
2 – Os cartazes previstos no número anterior incluem informação relativa às entidades às quais devem ser denunciadas situações de violência obstétrica.»

Artigo 7.º
Registo de procedimentos
Todos os atos médicos ou de enfermagem que sejam realizados durante o parto são obrigatoriamente registados com a devida justificação, em conformidade com as orientações e normas técnicas da Direção-Geral da Saúde.

Artigo 8.º
Erradicação da episiotomia de rotina
A realização de episiotomias de rotina e de outras práticas reiteradas não justificadas nos termos do artigo 7.º, sem prejuízo de responsabilidades civis e criminais que daí advenham, são objeto de: a) Penalizações no financiamento e sanções pecuniárias a aplicar aos hospitais, sempre que desrespeitem as recomendações da Organização Mundial de Saúde e os parâmetros definidos pela Direção-Geral da Saúde; b) Inquérito disciplinar aos profissionais de saúde. 3/4 Lei n.º 33/2025 31-03-2025 N.º 63 1.ª série

Artigo 9.º
Informação e sensibilização
1 – O Ministério da Saúde e o ministério com a tutela da igualdade de género são responsáveis por garantir os meios necessários à elaboração de um relatório anual com dados oficiais sobre satisfação relativamente aos cuidados de saúde e no parto e cumprimento dos planos de nascimento, respetivamente previstos nos artigos 9.º-A e 15.º-E da Lei n.º 15/2014, de 21 de março, e sobre o registo de procedimentos previsto no artigo 7.º
2 – O relatório previsto no número anterior e a realização de campanhas de sensibilização contra a violência obstétrica ficam a cargo da Comissão Multidisciplinar para os Direitos na Gravidez e no Parto.

Artigo 10.º
Comissão Multidisciplinar para os Direitos na Gravidez e no Parto
A presente lei cria a Comissão Multidisciplinar para os Direitos na Gravidez e no Parto, adiante designada Comissão, com as seguintes incumbências:
a) Promover campanhas de informação sobre os direitos na preconceção, na procriação medicamente assistida, na gravidez, no parto, no nascimento e no puerpério;
b) Promover campanhas de sensibilização pelo respeito dos direitos no parto e pela sua humanização, de modo a pôr fim a atitudes e a práticas que configuram a violência obstétrica;
c) Elaborar um relatório anual com dados oficiais sobre satisfação relativamente aos cuidados de saúde e no parto e cumprimento dos planos de nascimento,

respetivamente previstos nos artigos 9.º-A e 15.º-E da Lei n.º 15/2014, de 21 de março, e sobre o registo de procedimentos em conformidade com as orientações e normas técnicas da Direção-Geral da Saúde.

Artigo 11.º
Composição da Comissão
A Comissão Multidisciplinar para os Direitos na Gravidez e no Parto é composta por:
a) Um presidente designado pelo Conselho de Ministros, sob proposta dos membros do Governo responsáveis pela área da saúde e pela área da igualdade;
b) Quatro representantes dos utentes, eleitos pela Assembleia da República, por maioria absoluta dos deputados em efetividade de funções, incluindo representantes das associações de defesa dos direitos na gravidez e no parto;
c) Quatro membros nomeados pela Direção-Geral da Saúde, incluindo profissionais da saúde materno-infantil e da ginecologia/obstetrícia.

Artigo 12.º
Recursos e funcionamento da Comissão
A Comissão Multidisciplinar para os Direitos na Gravidez e no Parto funciona junto do Ministério da Saúde e do ministério com a tutela da igualdade, que devem garantir os meios necessários ao seu funcionamento.

Artigo 13.º
Regulamentação
O Governo procede à regulamentação da presente lei no prazo de 60 dias. 4/4 Lei n.º 33/2025 31-03-2025 N.º 63 1.ª série

Artigo 14.º
Entrada em vigor
A presente lei entra em vigor no dia seguinte ao da sua publicação e produz efeitos com a entrada em vigor do Orçamento do Estado subsequente à sua publicação.

Uruguay

Artículo 6
(Formas de violencia). - Constituyen manifestaciones de violencia basada en género, no excluyentes entre sí ni de otras que pudieran no encontrarse explicitadas, las que se definen a continuación:

[…]

H) Violencia obstétrica. Toda acción, omisión y patrón de conducta del personal de la salud en los procesos reproductivos de una mujer, que afecte su autonomía para decidir libremente sobre su cuerpo o abuso de técnicas y procedimientos invasivos.

Ley 21675
ESTATUYE MEDIDAS PARA PREVENIR, SANCIONAR Y ERRADICAR LA VIOLENCIA EN CONTRA DE LAS MUJERES, EN RAZÓN DE SU GÉNERO

Artículo 6.
Formas de violencia de género. La violencia en contra de las mujeres en razón de su género incluye, entre otras, las siguientes:

[…]

9. Violencia gineco-obstétrica: todo maltrato o agresión psicológica, física o sexual, negación injustificada o abuso que suceda en el marco de la atención de la salud sexual y reproductiva de la mujer, especialmente durante la atención de la gestación, preparto, parto, puerperio, aborto o urgencia ginecológica.

Notes on Editors

Marilisa D'Amico, PhD, is full professor of Constitutional Law, Department of Italian and Supranational Public Law, University of Milan.
She teaches "Constitutional Law and Women's Rights in the Constitutional State", and she thought for several years Constitutional Justice.
She is in charge of the Presidency of the inter-University Center "Culture di Genere", Scientific Coordinator of the Center "Migrazioni e Diritti umani", and of the Course on public methods for promoting gender equality.
She is member of the CRC-HCAI UNIMI Research Center in Human-Centered Artificial Intelligence.
She has been Chair holder and Academic coordinator of the European Fundamental Rights and Women's Rights (EFRiWoR) Jean Monnet Chair.
She has been Visiting Professor at the School of International and Public Affairs, Columbia University, New York City, in 2015 and 2017, at the Law School, Columbia University, New York City in 2019, at Fordham Law School in 2023, 2024, 2025, at Berkeley Law in July 2022 and June 2023, again at Columbia University, School of International and Public Affairs (January – June 2025).
Professor D'Amico's scientific research involves, among many others, two main core areas: Constitutional justice and human rights protection, with regard to, just to mention some of them,

issues pertaining to Voluntary Termination of Pregnancy, Medically-Assisted Procreation, LGBTQ+ rights, "Gender studies, and Women's rights".
She is the author of more than 300 publications among articles in scientific journals, edited books and monographic books, among which: *I diritti contesi. Problematiche attuali del costituzionalismo*, FrancoAngeli, 2016; *Una parità ambigua. Costituzione e diritti delle donne*, Raffaello Cortina Editore, 2020; *Parole che separano. Linguaggio, Costituzione, Diritti*, Raffaello Cortina Editore, 2023; with V. Onida, *Il giudizio di costituzionalità delle leggi in via incidentale. Materiali*, Giappichelli, 2025.

Costanza Nardocci, PhD, is associate professor in Constitutional Law, Department of Italian and Supranational Public Law, University of Milan, Italy.
She teaches "Gender Justice", "Women in Tech: New Frontiers of Gender-Related Rights and Artificial Intelligence", "Public constitutional Law", and "Constitutional rights of migrants in a comparative perspective". In previous years, she also taught "Women Empowerment and Sustainable Development", at the University of Milan, Department of Italian and Supranational Public Law.
She is teaching coordinator of the Post-Graduate Course on Gender-based violence held at the University of Milan.
She is member of the CRC-HCAI UNIMI Research Center in Human-Centered Artificial Intelligence.
She is member of the Steering Committee of the HAICU Lab Project within the U7+Alliance.
She has been Visiting Scholar in 2015, 2016, 2017, 2021 at the School of International and Public Affairs, and at the Law School, Columbia University, and at Fordham Law School in 2023, 2024.
Her scientific research involves constitutional law, national and supranational constitutional justice, and human rights law with a specific focus on: human rights; minority rights; gender studies; multiculturalism; anti-discrimination law; ethnic and racial discrimination; women's rights; indigenous people's rights; constitutional justice; artificial intelligence and discrimination.

She is the author of several publications in national and international scientific journals, edited volumes and special issues, and of three monographic books: *Razza e etnia. La discriminazione tra individuo e gruppo nella dimensione costituzionale e sovranazionale*, Editoriale Scientifica, 2016; *Il diritto al Giudice costituzionale*, Editoriale Scientifica, 2020; *Algoritmi, eguaglianza, discriminazione. Le sfide dell'intelligenza artificiale*, in corso di pubblicazione, Giappichelli, 2025).

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Notes on Contributors

Giussy Barbara is Associate Professor of Obstetrics and Gynaecology at the University of Milan and Director of the SVSeD (Service for Sexual and Domestic Violence), a public centre against gender violence at the Fondazione IRCCS Ca' Granda Policlinico Hospital, Milan. My main scientific interests are related to studying gender-based violence, including health, social and psychological aspects. I am also involved in several research projects related to the treatment of gynaecological diseases, in particular endometriosis and associated pain, infertility and sexual function. My research activities are documented in several papers published in peer-reviewed scientific journals. I am an ad hoc reviewer for several international journals.

Dominique Bernier is a professor in the Department of Legal Sciences at UQAM (Université du Québec à Montréal). A member of the Quebec Bar since 2008, she holds a master's degree in law from Université Laval and a doctorate in law from the University of Ottawa. Her current research focuses on specialized courts (drug, alcohol, domestic violence), access to justice, recognition of gender-based violence and possible remedies (family law, criminal law), alternative forms of justice and discrimination. In addition to her various research interests, she has been involved with various community organizations (street youth, mental health, visual arts, advocacy, injection drug users, etc.).

Irene Cetin is full professor of Obstetrics and Gynecology at the University of Milan and head of Obstetrics at the Mangiagalli

Policlinico Hospital of Milan, one of the most renown maternity units in Italy. Within the University she is the head of the 'Laboratory of Maternal-Fetal Translational Research Giorgio Pardi'. She is the past president of the Italian Society of Perinatal Medicine. Professsor Cetin has coordinated several research projects funded by national as well as European granting bodies. Her research group is composed of physicians and biologists working on the study of human pregnancy and placental function. Particularly, she has been working on understanding placental function and mechanisms regulating fetal oxygenation and growth. She has an expertise in maternal and fetal nutrition and has been studying pregnancy pathologies such as FGR, preeclampsia, preterm delivery and gestational diabetes.

Camila Díaz Pacheco is a legal researcher specializing in gender and international human rights law. She holds a Master's degree in Law from the University of Milan, where she graduated cum laude with a thesis on obstetric violence and minority women. Her work focuses on the intersection between legal systems and gender-based institutional violence. Camila has published on the international responsibility of states for obstetric violence and collaborates with the Observatorio de Violencia Obstétrica de Chile. She is currently co-authoring comparative research on legal frameworks addressing obstetric violence in Latin America.

Sara Di Giovanni is a Ph.D. candidate in Constitutional Law at the University of Milan (*Università degli Studi di Milano*), where she is currently conducting her doctoral research on the right to sexual orientation. She serves on the editorial board of the Observatory on Violence Against Women at the University of Milan and has been an active participant for several years in the university's advanced course on gender-based violence. Her scholarly work focuses on gender-based violence, reproductive rights, and the rights of homosexual individuals, and she is the author of several publications on these subjects.

Audrey Ferron-Parayre is Associate Professor at the University of Ottawa Faculty of Law, Civil Law Section and a member of the

University of Ottawa Centre for Health Law, Policy and Ethics. Her research and teaching interests focus on the law of persons, health law, and legal effectiveness. Holding a master's degree in public health and a doctorate in law, her interdisciplinary background leads her to use empirical research methods, both qualitative and quantitative, in her various research projects. She is currently leading two major research projects regarding law and obstetrical and gynecological violence, financed by the Canadian Institutes of Health Research and the Social Sciences and Humanities Research Council of Canada.

Francesca Gigli earned her degree in Medicine and Surgery from the University of Milan. In 2021, she entered the residency program in Obstetrics and Gynecology at the Mangiagalli Clinic, Fondazione IRCCS Ca' Granda, Ospedale Maggiore Policlinico, Milan. Passionate about maternal and fetal care, she combines clinical practice with academic research, with a special focus on obstetrics, particularly labor and delivery. She has been actively involved in research projects, with presentations at national and international congresses and contributions to scientific publications. She is currently in Spain for a one-year off-site training rotation in fetal medicine to further enhance her skills in obstetric ultrasound.

Laila Micci has been working as a psychotherapist for SVSeD (Service for Sexual and Domestic Violence), a public centre against gender violence at the Fondazione IRCCS Ca' Granda Policlinico Hospital, Milan, since 2007. Since 2017, she has been coordinating the SVSeD psycho-social team. She is currently employed as a lecturer at Università Cattolica Milan, where she is responsible for the module entitled "Support interventions in domestic and sexual violence". She is a certified psychotherapist with advanced training as an EMDR (Eye Movement Desensitization and Reprocessing) practitioner.

Francesca Rescigno is professor of Public Law and Equal Opportunities Law at the University of Bologna. Her research interests include the Italian parliamentary system, the Israeli form of government, and the constitutional functions of regions. In recent years, she has focused

particularly on the study of the principle of equality in its various forms: from equality without distinction of sex to equality beyond the barrier of species, hoping to make a small but significant contribution to the creation of a "fairer" world for all.

Edgardo Somigliana graduated in Medicine and Surgery in 1994 and specialised in Obstetrics and Gynaecology in 1999. In 2006, he obtained a PhD in Prenatal Medicine. He is currently Head of the Medically Assisted Procreation Unit and the Obstetrics and Gynaecology Emergency Department at the Policlinico Hospital of Milan. He is also a full Professor at the University of Milan. He is the editor-in-chief of the journal Human Reproduction Open. His main scientific interests are infertility and endometriosis. He has authored or co-authored over 490 articles in international journals and has an h-index of 79 (Scopus).

I diritti negati
diretta da G. Zagrebelsky, M. D'Amico

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Psicologia, benessere, autoaiuto
Efficacia personale
Politiche e servizi sociali

FrancoAngeli

La passione per le conoscenze

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Obstetric and gynecological violence represents one of the most neglected forms of violence against women.

Difficult to define by the law, challenging to detect in daily practices, hard to prove and sanction before domestic and supranational Courts.

Although violence against women gained increasing legal resonance in the past few decades, obstetric and gynecological violence remains at the periphery of the constitutional and human rights law debate.

The book intends to shed light on the intersection among women's human rights, violence, and reproductive rights, examining how and to what extent women are exposed to human rights violations and abuse in the exercise of their right to private life, sexual health, and reproduction.

Interlacing the legal and medical perspectives, the book aims to offer a national, comparative, and supranational analysis while paving the way to legislative mechanisms to effectively tackle obstetric and gynecological violence in the global scenario.

Marilisa D'Amico, PhD, is full professor of Constitutional Law at the University of Milan, Department of Italian and supranational public law. She teaches Constitutional Law and Women's Rights in the Constitutional State at the University of Milan. She is a national and international renown leading scholar in the fields of gender studies. She is the author of several monographs, edited books and articles published in scientific journals, among many topics, dedicated to the rights of women, with a key focus on: reproductive rights, particularly about abortion and medically-assisted procreation technologies; women's political representation, and gender-based violence.

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