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# Obstetric Violence and Abortion. Contributions to the Debate in Colombia

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Grupo Médico por el Derecho a Decidir - Colombia  
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The **Grupo Médico por el Derecho a Decidir** is a network of doctors from different medical specialties that advocates for timely, comprehensive access for women to sexual and reproductive healthcare services, grounded in respect for their freedom to make choices. It is part of the Global Doctors for Choice (GDC) network.

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# Introduction

The *Grupo Médico por el Derecho a Decidir* is part of the Global Doctors for Choice network, which extends over different regions of the world (Africa, North America, Europe and Latin America). At this juncture, Grupo Medico wishes to publically state its position regarding Obstetric Violence (OV) during birth and abortion procedures. From our standpoint as doctors belonging to different specialties OV is a form of gender-based violence that infringes upon the fundamental rights of any woman who requests medical assistance when giving birth or when having an abortion procedure.<sup>1</sup>

As time passes, evidence alluding to the frequency with which medical and other healthcare personnel engage in disrespectful and violent practices has come to light. It can be said that this takes place as a result of sociocultural constructs that normalize violence against women.

As medical professionals who are committed to promoting and defending women's rights, especially their right to make un-coerced and informed decisions regarding their bodies and their sexual and reproductive health, we henceforth publically state our opinion regarding the need for a human rights framework regarding OV during

abortion and birth. Such a framework is necessary as it has not been effective to frame this in terms of customer satisfaction, because of the cultural and moral attitudes and traditions influencing healthcare providers

Stemming from our commitment to defend a woman's right to choose, we insist on the need for public policy to protect a woman's right to not experience discrimination, be attacked or mistreated for gender-based reasons in any areas of her everyday life, including her health.

# 1. Evidence and conceptual framework

## **Violence against women**

Violence against women is defined as any physical, sexual or psychological aggression that takes place at a domestic or community level, perpetrated by another person; acts of violence include but are not limited to : rape , sexual abuse, sexual harassment, human trafficking, forced prostitution and kidnapping; this may occur in the workplace, in educational institutions, health establishments, or any other place, and can be perpetrated or condoned by the state or its agents, wherever it takes place.(1)

It is estimated that approximately 35% of women are victims of gender based violence worldwide and more than 70% of them will suffer continued violence during their

lifespan. Healthcare costs and direct productivity costs range from 5.800.000 USD in the United States to 13.600.000 USD in Australia and 22.900.000 Lbs. in the UK. Gender based violence is therefore a public health problem that demands changes in state policy and health initiatives aimed at eradicating it. (3)

Recognizing any form of aggression as violence against women allows us to conceptualize it as an infringement upon fundamental rights and visualize it's occurrence in different contexts, public and private. It can be said that the infringement upon women's rights transcends the domestic sphere and is easily identifiable in public practices, both individual and institutional, as will be explained later on.

## **Violence against women as an infringement on Human Rights**

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Different international Human Rights conventions and declarations which have been signed by Colombia and incorporated into our constitution and public policy, ratify that every woman in this country is entitled to a life that is free of violence in the public and private sphere, to exercise her human rights and to enjoy the personal freedoms which are (nationally and internationally) inherent to these rights, which include: (8) The right to respect for life; (b) The right to respect for physical, psychological and moral integrity; (c) The right to freedom and personal safety; (d) The right to not be subjected to torture; (e) The right to have her dignity respected and her family protected; (f) The right to equality of protection from the law and by the law; (g) The right to a straightforward and time-efficient legal process to seek protection against acts that violate her rights; (h) The right to freedom of association; (i) The right to profess her own religion and beliefs within the framework of the law; and (j) The right to equality of access to public office in her country and to participate in public affairs , including decision making processes. (1)

Violence against women, is a violation of rights and fundamental liberties, and infringes upon the exercise of said rights and liberties. It is important to add that certain risk factors make women more vulnerable to violence such as belonging to ethnic minorities, being a refugee or a migrant, living in a rural, reclusive or remote environment, being

homeless, age (being a child or being elderly), being disabled and especially, being exposed to armed conflict (3).

Therefore, it can be said that certain practices , performed by healthcare personnel during obstetric services in situations where women are giving birth or having an abortion, can be considered forms of violence against women.

Obstetric Violence (OV) has been defined as «the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women». (4)

## Types of obstetric violence

Two studies about obstetric violence from Venezuela and Nigeria show a prevalence that varies between 79,5%and 98% (5, 6, 7)<sup>2</sup> with performance of procedures without consent as the most frequent form of mistreatment and nurses as the main offenders, with serious impact on the health of pregnant women and newborn babies (7-10)]. In a Nigerian study , 98% of puerperae reported having suffered some type of obstetric violence and declared procedures implemented without consent as the most prevalent form of OV (54,5%) , followed by physical abuse (35,7%). (6). Venezuelan women identified the nursing staff as the main perpetrators of OV (67, 5%) followed by doctors (53%) (11).

Reported repercussions for women who are victims of OV include different degrees of post-traumatic stress disorder (from irritability to full-fledged depression and suicidal ideation). (8-10). Repercussions for the children of these women have also been reported, especially in relation to their subsequent mental health, including retardation

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<sup>2</sup> In spite of the fact that these studies were performed on significant population samples, the results still need to be replicated in order to make sure that they represent the reality of the situation.

of cognitive development, physical development and behavioral patterns. There is also evidence of metabolic problems in adulthood. (12)

There are numerous practices which can be catalogued as OV, most of which take place during childbirth, and only a handful of studies refer to obstetric violence during abortion.<sup>3</sup> These practices can be divided into two categories: dehumanizing treatment and medical interventions performed without consent (11).

Medical interventions performed without consent include routine procedures that take place during obstetric service provision which are not medically necessary or clinically justified. In these instances women are not informed and do not give their consent. Scientific evidence indicates that such practice is unnecessary and even dangerous. The most frequent procedures are: inducing labor with oxytocin- some studies show that at least 92.7% of labors are routinely induced – (13); performing enemas, shaving , multiple vaginal exams by different members of the medical staff; imposing supine positioning/ restraining movement; performing an episiotomy, performing the Kristeller maneuver, performing unnecessary C-sections- prevalence surpasses 38% , which is significantly higher than the WHO recommends-(14) forbidding family members from entering the birthing room; not providing appropriate and timely information and not asking for informed consent (15).

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Additionally, the most common dehumanizing practices include: Criticizing the woman for crying or screaming during labor, forbidding her from asking questions and expressing her fears or doubts; mocking her, making ironic disparaging remarks, restraining her or hitting her, intentionally refusing to administer pain relief or anesthesia and preventing her from forming an early attachment to her child when this is not medically necessary. (16)

The origin of OV can be traced back to the following factors: a patriarchal culture which has appropriated the natural processes of a woman's life (16); the power dynamic between medical personnel and the birthing mother (17); over-reliance on

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<sup>3</sup> Because of this, our group held two meetings during 2015 to analyze the experiences of different specialists and service providing entities, in order to gain a better understanding of this type of OV.

technology (18) and society's violent dynamics which permeate and influence hospital environments (19).

Having analyzed OV during labor, it is also important to focus on the occurrence of this phenomenon during abortion. In this case, elements like idiosyncratic attitudes and beliefs, socio-cultural precepts (moral, religious, legal) and institutional traits (professional codes of conduct, union law) converge, with a significant impact on the provision of services according to the implementation of Law 100 and on the health and dignity of women.

## Obstetric violence during abortion

After two meetings where the experiences of different health professionals and service providing institutions were analyzed, our group was able to conclude that even though nine years have passed since the C-355 ruling of 2006, a woman who has been able to overcome all the different access barriers to obtain a safe and lawful abortion procedure is still frequently exposed to rights infringements when she receives pregnancy termination services. Some of the most common practices are:

- Breaches in confidentiality: Speaking to the woman in front of other people using stigmatizing terms or alluding to her decision in a derogatory manner («the one who's having an abortion»), and/or offering no privacy during medical consultations and physical examinations.
- Degrading healthcare practices/Discrimination: Not advising the woman of her rights, withholding reliable, impartial information, delaying medical attention and/or procedures, delaying or denying the allocation of a hospital bed and deliberately placing a woman next to mothers with their newborns to «teach her a lesson».
- Sub-standard care: Use of inadequate or obsolete technology: using curettage (D&C) instead of Vacuum Aspiration.

- Physical Abuse: Insufficient pain relief or no pain relief at all.
- Psychological abuse: Threatening, accusing, blaming, humiliating, re-victimizing and/or trying to change her mind.

The stigma of abortion can be perpetrated by self-recrimination and feelings of guilt, which lead women to accept being mistreated, and by medical personnel who believe that healthcare resources are being spent on a patient who «did this to herself».

## Determinants for obstetric violence during abortion

Determining factors are defined as a series of personal, social, economic and environmental traits that define the health status of individuals or populations.

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Determining factors for OV can range from broad scope (the absence of policy and/or a legal framework) to more specific community-based and individual mechanisms which de-legitimize the act of requesting an abortion.

### Legislative Mechanisms:

Regarding legislative mechanisms, we highlight the absence of a defined set of laws and national policies that address the subject of OV specifically, much less any that address OV during abortion services ; secondly, we note the lack of legal recourse or compensation for victims of OV or women who have had their sexual and reproductive rights infringed upon; lastly we see the absence of any kind of leadership or rule enforcement in these health providing institutions , as well as the absence of any accountability mechanisms.

### Institutional Mechanisms:

In the institutional sphere, three different types of factors can be identified:

- The training of personnel: It can be said that educational institutions in the health arena promote authoritative and paternalistic professionals who do not recognize the right of a pregnant woman to make decisions regarding her own body. These professionals tend to underestimate and disqualify her knowledge and do not recognize their own disrespectful behavior towards her. Additionally, it is clear that there is an important lack of health professionals with a specific training in abortion within general obstetric services, in part because most of them received their training when abortion was totally banned. There is also a lack of professional development opportunities in this field, which negatively influences the quality of services provided.
- There is a significant lack of knowledge among medical professionals about the Colombian legal framework regarding abortion. A wider, more complete interpretation of the C-355 ruling of 2006 is needed, especially when it comes to late-term abortions and health-related abortions, specifically when they stem from mental health-related issues.
- Lack of standardized procedures: the protocol established for abortion services is often misapplied, putting women through unnecessary, re-victimizing interventions that delay the process such as: Being evaluated by a psychology team (in spite of falling in one of the decriminalized categories set within the C-355 ruling) and forcing them to have an unnecessary ultrasound or medical test.
- Insufficient physical infrastructure: evinced by a lack of special facilities (for surgery and hospitalization) for women to request legal abortion services, which means that they are often treated alongside women who are in labor.

### Community Mechanisms:

Attitudes and beliefs that are shared by different societal groups lead to the «normalization» of disrespectful and abusive behaviors during childbirth and abortion services, based on judgments that arise from culturally and socially established values.

Thus, communities become places where norms, judgments and socially condoned abuse or disrespect towards women are perpetrated, as opposed to becoming places of commitment to enforcement of human rights.

In addition to the community factors we have already mentioned, there is a significant gap in sexuality and human rights education, which includes sexual and reproductive rights. This leads women to implicitly renounce their rights and to assume that mistreatment is «normal».

### Individual Mechanisms:

Other mechanisms can be identified that affect health providers and abortion service users. On this level we are able to see interventions that are disrespectful and may infringe upon a woman's rights take place as a result of circumstantial and idiosyncratic variables that converge during service provision.

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First, we must point out that women and health providers subjectively experience events and as a result, their accounts sometimes differ significantly. On one hand, women are placed in a new situation, an unknown social and physical environment; on the other hand, health providers find themselves performing a routine procedure in a very familiar social and physical environment. In light of this, a task that might seem mundane to the nurse and the attending physician might generate genuine anguish and fear for the woman seeking their services.

Secondly, we are able to identify a significant gap in women's knowledge regarding their rights to make decisions about their bodies, specifically when it comes to whether or not they meet the criteria to obtain a legal abortion. This is a consequence of having received an education which failed to address sexual and reproductive rights (a common occurrence in our educational system), making it impossible for a woman to assert her rights at the moment of receiving health services.

Concerning medical staff, it is important to highlight the inappropriate citation of conscientious objection, which, added to other variables like exhaustion, frustration and lack of institutional resources to meet the needs of many seeking care, may negatively influence service provision. In light of this, a woman requesting an abortion,

together with her needs, fears and particular objections, are perceived as obstacles and inconveniences which encroach on the health provider's everyday activities, adding pressures which ultimately result in service delays or outright refusals.

It can be said that individual mechanisms are unpredictable and difficult to control; this highlights the need for strategies that target communities, institutions and public policy, minimizing the impact of variables linked to specific situations and people involved in abortion service provision.

## 2. Legal Framework

Several international health organizations have developed specific agendas regarding the defense of human rights and women's sexual and reproductive rights.

The World Health Organization (WHO 1996) identified the prevention of violence (including violence against women) as a public health priority requiring immediate action. In 2002 the first international report about violence and health was published, which included a chapter about domestic and sexual violence (20).

The international federation of Gynecology and Obstetrics (FIGO 1997) made a declaration regarding violence against women, highlighting the role that this organization and its affiliates have played in the management of the problem.

Later, in 2009, FIGO published a report about ethical issues in obstetrics and gynecology, including several recommendations promoting respectful healthcare provision during childbirth and revising several relevant ethical principles for respectful interactions

during childbirth such as: informed consent, confidentiality, privacy and doctor-patient relationships (19).

Recently the WHO issued a statement about the «prevention and eradication of disrespect and mistreatment during childbirth in healthcare facilities», adding that «Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination». It demands «greater action, dialogue, research and advocacy on this important public health and human rights issue» (21). Similarly several countries in Latin America and the Caribbean have approved laws and reforms that bar/ penalize violence against women (22).

In spite of these advances, only three countries have currently included OV in their legislation: Venezuela (2006) with their «Organic law regarding Women's right to a life free of violence» (4), Argentina (2009) with their «Law of integral protection to prevent, sanction and eradicate violence against women in the contexts where they develop interpersonal relationships» (22, 23) and Mexico (2014) with their «General law of access to a life free of violence» (24).

In Colombia, law 1257 has been in place since 2008 which «dictates norms regarding disseminating, preventing and sanctioning all forms of violence and discrimination against women». This law does not mention OV specifically but it clearly defines violence against women stipulating different types of violence which are similar to those included within the previously mentioned OV laws. (25).

### 3. The issue of obstetric violence during voluntary pregnancy interruption:

*Alejandra<sup>4</sup>, 20 years old, is pregnant as a result of sexual violence. She requests an abortion after presenting the necessary paperwork (in this case, a police statement). After a medical evaluation and a counseling session she is swiftly referred to the health official in charge of authorizing the service to be covered by her health insurance provider. When Alejandra's name is called in the waiting room, she attempts to enter the*

office with her partner, at which point the health official says loudly and for everyone to hear «you have to come in alone because it's your child that we are going to kill».

That same day, Alejandra is referred to a hospital, where instead of calling out her name in the waiting room, they call out «the one that's here for an abortion can come in now!»

While obtaining her informed consent, the health official verbally states that the risk of dying due to an abortion is high, adding that Alejandra should take full responsibility.

Once Alejandra is hospitalized, she receives standard medical care without complications and her physical recovery is satisfactory. The same cannot be said for her emotional recovery, she adds, owing to the humiliation she repeatedly experienced.

Monica, a 38 year old professional, requested an abortion after her fetus was diagnosed with severe malformations. The news devastated her. During her hospitalization and while she was being administered the necessary medications to terminate her pregnancy, she was repeatedly visited by hospital staff, entering her room to pray with religious paraphernalia, asking her to change her mind. Once the procedure had taken place the assisting nurse told Monica that «she hoped that one day she would be forgiven for her sin».

Maria, 14 years old, had never left her village. She was raped in the context of the armed conflict and after facing several access barriers, including threats to her personal integrity and referrals to several different institutions, she was able to obtain an abortion in a city that was very far from her village. By this time she was 18 weeks into her pregnancy. She was not allowed to see or talk to any members of her family while she was hospitalized in the delivery room. When she was discharged, she was handed the fetus in a plastic container under the pretense that «it was her responsibility to dispose of it, after what she had done».

Andrea, a 21 year old student, requested an abortion to end her eight week pregnancy because carrying it to term entailed a significant risk to her mental health, as certified by a medical doctor and a psychologist. She was hospitalized in a delivery room, on a stretcher next to women who were either in labor or had recently given birth. She was

*denied food over the course of three days, while she waited for an OBGYN who was not a conscientious objector to come on duty. One of the health professionals present during this delay, said to her that «he would never be fooled by her phony depression and distress» while another health official asked the nurses to place Andrea next to mothers with newborns so that she would have a chance to really consider her decision.*

*By the fourth day, Andrea began taking the prescribed medication for her abortion, which, as a foreseeable side effect, caused her severe pain and diarrhea. The procedure took longer than expected because a non-objecting health professional wasn't always available to administer the medications within the prescribed interval. After 24 hours during which Andrea received no pain medication and no help to clean herself up, and after being repeatedly reprimanded for crying, she was able to completely expel the contents of her uterus without complications. In spite of this, she was forced to wait 8 more hours in order to have an unnecessary D&C. When she was taken to the operating room, she remained there, naked, with her legs spread and her feet mounted on stirrups for several minutes during which the OR doors were wide open and several people were walking past.*

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In the situations which have been described, it is possible to identify a considerable number of acts and omissions that infringed upon these women's fundamental rights.

It can be said that these violations start with the difficulties experienced while trying to access the health services that these women are entitled to by law. Once these services are obtained, women are subjected to practices and attitudes that range from lack of emotional support and empathy during a difficult time to events that would constitute torture such as forced internment and public humiliation.

**Violation of the right to health:** Underestimation of the importance of mental health within the framework of the law and mocking, and questioning the veracity of emotional symptoms, even after the appropriate certifications have been obtained. Some of the practices observed during treatment can even be said to pose potential risks to the mental and physical health of the women receiving abortion services.

**Denial of services by health providing institutions:** This type of denial is traditionally exercised and understood as «conscientious objection», an illegitimate mechanism

which has been recently replaced with the phrase «we are not equipped to perform this procedure», which is in itself misleading, as institutions are routinely equipped to provide services (in this case, obstetric services) rather than procedures. This denial forces women to go from place to place asking for abortion services, placing a burden on them which should be assumed by their health insurance providers. There should be an effective referral system, with clear service routes and with mechanisms in place to hold institutions accountable for accessible and high quality services.

**Victimization of the most vulnerable populations:** Frequently, women who require abortions are in vulnerable situations (they are victims of violence, suffering from illness, emotionally frail, minors, lacking a support network, etc.). Instead of leading to supportive treatment this vulnerability is exploited by healthcare personnel to the patients' disadvantage. For example, young women are often stigmatized as irresponsible, and women suffering from mental illness are perceived as immature and incapable of making decisions regarding their bodies or their sexual and reproductive health.

**Discrimination against women and disregard for their status as subjects of law:** Occasionally, due to religious and/or moral considerations, priority is accorded to the life of the embryo or fetus rather than to a woman's right to receive treatment when her life or health is at risk. When a woman is forced to listen to arguments against her decision and she is exposed to the fetus in an unsolicited and cruel way, she is no longer regarded as a person, or as a woman, as her worth is ascribed to the acceptance of maternity.

**Exposure to unsolicited or misleading information regarding health and rights:** Exaggerating the risks associated with abortion, denigrating the woman's decision by comparing it to murder, and downplaying the risks associated with carrying a pregnancy to term can be seen as practices that infringe upon the right to information. On occasion, these may represent insurmountable access barriers but sometimes, even when the woman is able to obtain a procedure, they may lead to suffering and emotional burdens comparable to torture.

**Confidentiality Breaches:** Public exposure as a mechanism to foster derision or stigmatization, and breaching medical confidentiality (for Example, when medical

personnel who are not assigned to the patient intervene with coercive or fear mongering ways), are a clear violation of the right to privacy.

**Disavowing the right to freedom of beliefs:** Religious intervention with the aim of dissuading the patient, imposition of medical personnel's own religious beliefs against abortion, and forcing patients to witness religious manifestations, all constitute violations of the right to freedom of beliefs which places women in a false position of moral inferiority.

**Torture and degrading treatment:** Long waiting periods, denial of food, denial of assistance to patients, denial of pain management options, nudity, exposure, performing unnecessary or obsolete procedures, and over-medicalization can be regarded as everyday occurrences in the obstetric ward which are seldom perceived as humiliating by medical personnel and patients alike. In the context of abortion, these practices may be intended as mechanisms of social punishment and indoctrination. On other occasions, these events can occur as a result of substandard services due to the stigmatization of abortion as an undesirable medical procedure. Examples of this include the lack of specific training for medical personnel, poor infrastructure, and almost non-existent accountability mechanisms or sanctions for health professionals who discriminate against patients who request an abortion.

## 4. Conclusions

Based on the previous arguments, our group distinguishes OV as any kind of treatment that is disrespectful toward women, including the performance of medical procedures on pregnant women without their consent. Violence towards women encompasses OV, a phenomenon that takes place in our country and infringes women's sexual and reproductive rights. Our group understands that OV originates on different levels, personal, societal and institutional, and has significant consequences for the overall health of women and their children during labor.

In the specific case of abortion, there are aggravating factors which heighten the intensity and the consequences of violent practices, starting with the obvious trivialization in political, academic, and legislative discourse, of abortion as a procedure where women can become victims of obstetric violence.

Social disdain and judgment towards women who decide against maternity exacerbates the rest of the factors that normally play a role in the exercise of violence towards women during labor, and aggravate the stigma and alienation experienced by those

who decide to have an abortion. These factors converge, leading women to believe that they actually deserve to be mistreated, or do not perceive ill treatment and lose the ability to assert their own rights.

Based on the meetings led by our group, it can be said that OV may manifest in different ways during abortion procedures. Amongst these we can find: total disregard for the woman, according higher priority to the embryo or fetus than to her fundamental rights; strategies to dissuade her, such as unnecessarily long hospitalizations, needless referrals to different health professionals, punitive attitudes toward women who make decisions about their bodies and sexual/reproductive health, and exposure to situations where the woman is treated alongside women in labor.

We were able to identify ways in which OV is perpetuated in cases of abortion which need to be addressed and attenuated in the near future, such as the insufficient academic training of health professionals, which does not provide a framework on the topic of human rights or sexual and reproductive rights. This academic gap must be addressed. Another aggravating factor is the separation at an institutional and public policy level between programs aiming to improve safe maternity and those overseeing access to abortion disregarding any associations that safe abortion practices may have with safe maternity. This leads to an absence of regulation, vigilance and control mechanisms.

Based on these considerations, the *Grupo Médico por el Derecho a Decidir* is able to interpret OV in cases of abortion as a problem that encompasses the entire spectrum of violence against women. It is therefore important to address the fundamental aspects of the issue such as lack of academic research on the subject, the need for conceptualizing, and developing categories of OV specific to abortion, and the identification of other perpetuating factors.

## 5. Recommendations

Based on this document, we are able to make the following recommendations in order to guarantee dignified and appropriate medical attention for women who request an abortion in health providing institutions:

### **Individual and Community Levels:**

- Include and promote human rights and sexual and reproductive rights within school syllabi.
- Educate and empower women to recognize and assert their fundamental rights and their sexual and reproductive rights, especially when requesting

an abortion. In this situation they must be aware that they are entitled to the same treatment as any other woman who requests other medical services.

## Institutional Level:

- Include the topic of obstetric violence in a human rights framework in healthcare education syllabi.
- Educate healthcare personnel regarding the current legal framework and medical protocols for women who request abortions.
- Sensitize administrative and assisting personnel regarding the dignified treatment of women who request abortion services, by providing information about gender issues and different perspectives when it comes to treating vulnerable populations.
- Identifying and reassigning conscientious objectors and other members of staff who are obstructing access, replacing them with non-objecting professionals.
- Provide physical infrastructure for women requesting abortions to be placed in separate areas from women who are in labor or postpartum.
- Guarantee the right to pain management, sedation and anxiety medication as well as the right to freely express physical and emotional pain and discomfort.
- Implement evidence-based practices and modern technologies for abortion procedures such as vacuum aspiration and appropriate medication administered at the correct intervals, avoiding the normalization of non evidence based medicalization and interventionism.
- Offer help and support to abortion service providers without discrimination.

- Establishing self-regulatory mechanisms, as well as vigilance and sanctions toward obstetric violence. These include actively seeking cases of mistreatment and providing the necessary routes for patients to be heard.

## Legislative level:

Including legislation that aims to define and describe obstetric violence in all its forms, in instances of childbirth and abortion service provision, so that clear mechanisms can be set in place for accountability and control, leading to the complete eradication of this issue.

## 6. References

1. Convención Interamericana para Prevenir, Sancionar y Erradicar la violencia contra la Mujer «Convención de Belem do Pará.» 1994. Available at: <http://www.oas.org/juridico/spanish/tratados/a-61.html>
2. Hechos y cifras: Acabar con la violencia contra mujeres y niñas. Available at: <http://www.unwomen.org/es/what-we-do/ending-violence-against-women/facts-and-figures2014>.
3. ONU Declaración sobre la eliminación de la violencia contra la mujer/Resolución de la Asamblea General 48/104 del 20 de diciembre de 1993.
4. Ley orgánica sobre el derecho de las mujeres a una vida libre de violencia. República Bolivariana de Venezuela. Fondo de Población de las Naciones Unidas (UNFPA). 2007; 1–91.

5. Terán P. et al. Violencia obstétrica: percepción de las usuarias. *Obstet Ginecol Venez*. 2013; 73(3):171-80.
6. Okafor II, Ugwu EO, Obi SN. Disrespect and abuse during facility-based childbirth in a low-income country. *Int J Gynaecol Obstet*. 2015; 128(2): 110-3.
7. Todd, A. M. (2013). The impact of a traumatic birth: An exploration of mothers' experiences. (Tesis de maestría no publicada). University of Chester, United Kingdom. Available at: <http://core.ac.uk/download/pdf/20072899.pdf>
8. Elmir R., Schmied V., Wilkes L., Jackson, D. Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *J AdvNurs*. 66. England: 2010 Blackwell Publishing Ltd.; 2010. p. 2142-53.
9. Ayers S., Eagle A., Waring H. The effects of childbirth-related post-traumatic stress disorder on women and their relationships: a qualitative study. *Psychol Health Med* 2006; 11:389-98.
10. Ayers S., Joseph S., McKenzie-McHarg K., et al. Post-traumatic stress disorder following childbirth: current issues and recommendations for future research. *J PsychosomObstetGynaecol*. 2008; 29:240-50.
11. Terán P., Castellanos C., González M. Violencia obstétrica: percepción de las usuarias. *RevObstetGinecolVenez* 2013; 73(3):171-80
12. Odent M. La vida fetal, el nacimiento y el futuro de la humanidad. Publisher Obstare. Tercera edición 2012.
13. Binfa L., Pantoja L., Ortiz J., Gurovich M., Cavada G. Assessment of the implementation of the model of integrated and humanised midwifery health services in Santiago, Chile. *Midwifery* 2013;29(10):1151-7.
14. Panorama de la salud 2007 indicadores de la OCDE. Available at: <http://www.oecdbookshop.org/get-it.php?REF=5KMMNT5689HK&TYPE=browse>

15. Warren C., Njuki R., Abuya T., Ndwiga C., et al. Study protocol for promoting respectful maternity care initiative to assess, measure and design interventions to reduce disrespect and abuse during childbirth in Kenya. *BMC pregnancy and childbirth* 2013;13(1):21.
16. d'Oliveira A. F., Diniz S. G., Schraiber L. B. Violence against women in health-care institutions: an emerging problem. *Lancet* 2002; 359:1681-5.
17. Faneite J., Feo A., Toro Merlo J. Grado de conocimiento de violencia obstétrica por el personal de salud. *RevObstetGinecolVenez* 2012;72(1):4-12.
18. Aguiar J., d'Oliveira, Schraiber L. B. Institutional violence, medical authority, and power relations in maternity hospitals from the perspective of health workers. *Cadernos de Saúde Pública* 2013;29(11):2287-96.
19. Bowser D., Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth. Boston: USAID-TRAction Project, Harvard School of Public Health. 2010.
20. Garcia-Moreno C., Stockl H. Protection of sexual and reproductive health rights: addressing violence against women. *Int J GynaecolObstet* 2009; 106:144-7.
21. OMS. Prevención y erradicación de la falta de respeto y el maltrato durante la atención del parto en centros de salud. Programa de Reproducción Humana. Declaración 2014. Available at: [http://apps.who.int/iris/bitstream/10665/134590/1/WHO\\_RHR\\_14.23\\_spa.pdf?ua=](http://apps.who.int/iris/bitstream/10665/134590/1/WHO_RHR_14.23_spa.pdf?ua=).
22. Ley Nacional 25.929 de parto humanizado. Derechos de padres e hijos durante el proceso del nacimiento. Available at: [www.msal.gov.ar/medicoscomunitarios/images/stories/Equipos/educacion-permanente-en-servicio/ley\\_nacional\\_25929.pdf2004](http://www.msal.gov.ar/medicoscomunitarios/images/stories/Equipos/educacion-permanente-en-servicio/ley_nacional_25929.pdf2004)
23. Ley Nacional 26.485 de protección integral paraprevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones

interpersonales. Available at: [www.msal.gov.ar/medicoscomunitarios/images/stories/Equipos/educacion-permanente-en-servicio/ley\\_nacional\\_26485.pdf2009](http://www.msal.gov.ar/medicoscomunitarios/images/stories/Equipos/educacion-permanente-en-servicio/ley_nacional_26485.pdf2009)

24. GIRE. Omisión e indiferencia derechos reproductivos en México. Available at: <http://informe.gire.org.mx/caps/cap4.pdf>
25. Ley 1257 de 2008 «Por la cual se dictan normas de sensibilización, prevención y sanción de formas de violencia y discriminación contra las mujeres, se reforman los Códigos Penal, de Procedimiento Penal, la Ley 294 de 1996 y se dictan otras disposiciones». Available at: [www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=34054](http://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=34054) [Marzo, 2015].

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