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Francesca Basso

# In Pain Thou Shalt Bring Forth Children?

## For a Human Right to Pain Relief in Childbirth

EMA, The European Master's Programme in Human Rights and Democratisation

FRANCESCA BASSO

# IN PAIN THOU SHALT BRING FORTH CHILDREN? FOR A HUMAN RIGHT TO PAIN RELIEF IN CHILDBIRTH

# FOREWORD

The European Master's Degree in Human Rights and Democratisation (EMA) is a one-year intensive programme launched in 1997 as a joint initiative of universities in all EU Member States with support from the European Commission. Based on an action- and policy-oriented approach to learning, it combines legal, political, historical, anthropological and philosophical perspectives on the study of human rights and democracy with targeted skills-building activities. The aim from the outset was to prepare young professionals to respond to the requirements and challenges of work in international organisations, field operations, governmental and non-governmental bodies, and academia. As a measure of its success, EMA has served as a model of inspiration for the establishment of six other EU-sponsored regional master's programmes in the area of human rights and democratisation in different parts of the world. These programmes cooperate closely in the framework of the Global Campus of Human Rights, which is based in Venice, Italy.

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Each year the EMA Council of Directors selects five theses, which stand out not only for their formal academic qualities but also for the originality of topic, innovative character of methodology and approach, potential usefulness in raising awareness about neglected issues, and capacity for contributing to the promotion of the values underlying human rights and democracy.

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• Basso, Francesca, *In Pain Thou Shalt Bring Forth Children? For a Human Right to Pain Relief in Childbirth.* Supervisor: Helena Pereira De Melo, New University of Lisbon.

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The selected theses demonstrate the richness and diversity of the EMA programme and the outstanding quality of the work performed by its students. On behalf of the Governing Bodies of EMA and of all participating universities, we congratulate the authors.

Prof. Manfred NOWAK
Global Campus Secretary General

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University of Lisbon.

This publication includes the thesis *In Pain Thou Shalt Bring Forth Children? For a Human Right to Pain Relief in Childbirth* by Francesca Basso and supervised by Helena Pereira De Melo, New University of Lisbon.

## BIOGRAPHY

A former language teacher, Francesca Basso has a background in Languages and in International Relations. She then specialised at the European Master's Programme in Human Rights and Democratisation. Her academic and political interest focuses especially on gender issues and feminist studies.

## ABSTRACT

In recent years, increasing attention has been dedicated to the quality of childbirth conditions for women around the world, following the wave of civil society movements that promoted the protection of human rights in childbirth.

In this context, a crucial factor to be addressed is pain and its management: this thesis stems from the observation that there is an absence of any human right to pain relief in childbirth, even though studies show that many women who complained about their pain were ignored, disbelieved or not taken seriously, and that pain relief was denied to them, even when they explicitly requested it. I decided to explore the reasons underlying the little attention dedicated to this issue, both on the part of institutions and on the part of medical staff. This thesis analyses the meanings and values attached to pain in childbirth, which are deeply influenced by religious and cultural beliefs; it then examines the present international human rights framework on pain relief.

This analysis reveals that gender plays a fundamental role in making women's pain in childbirth undervalued and often unseen, and that, ultimately, the denial of pain relief in childbirth can be regarded as a violation of human rights and as a type of gender-based violence. Therefore, I support a human right to pain relief in childbirth and hypothesise that obstetric violence is a potentially effective device to confront the neglect of pain relief in childbirth in medical facilities.

*Keywords: pain, pregnancy, childbirth, gender, stereotypes, pain relief, human rights, women's rights, gender-based violence, obstetric violence*

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# TABLE OF ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired immune deficiency syndrome |
| CEDAW | United Nations Convention on the Elimination of All Forms of Discrimination Against Women |
| CESCR | United Nations Committee on Economic, Social and Cultural Rights |
| CIDT | Cruel, inhuman and degrading treatment |
| ECHR | European Convention on Human Rights |
| ECtHR | European Court of Human Rights |
| ECPT | European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment |
| GBV | Gender-based violence |
| IASP | International Association for the Study of Pain |
| ICCPR | International Covenant on Civil and Political Rights |
| ICESCR | International Covenant on Economic, Social and Cultural Rights |
| ICI | International Childbirth Initiative |

| | |
|---|---|
| IFFHRO | International Federation of Health and Human Rights Organisations (now known as IFFHRO Medical Human Rights Network) |
| HIV | Human Immunodeficiency Virus |
| NGO | Non-governmental organisation |
| SR | Special Rapporteur |
| UDHR | Universal Declaration of Human Rights |
| UN | United Nations |
| UN HRC | United Nations Human Rights Council |
| UNVFVT | United Nations Voluntary Fund for Victims of Torture |
| VIP | Voluntary interruption of pregnancy |
| WHO | World Health Organization |

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# INTRODUCTION

'This one is really stupid, she doesn't get that this is what childbirth feels like'

'Didn't you like to open your legs? Then now shut up'

'Oh, here comes the one who was not able to endure natural childbirth'

'I asked for anesthesia and it was denied'[1]

'The attendant refused when I needed to hold her while I was in pain and said it wouldn't change anything'[2]

'This is what happens when you like men too much'[3]

These extracts are part of real-life stories told by women who gave birth in medical facilities located in different countries (Chile, Croatia and Ghana). The humiliation, belittling and infantilisation encountered by these women, simply for voicing their pain during childbirth, is appalling. This type of treatment, although – luckily – not endemic in medical facilities, is more common than one might think – in fact, in my country (Italy), 41% of women[4] report experiencing humiliating

[1] Vanessa Vargas Rojas, '"Dijo que si nos gustó abrirnos aguantáramos ahora": Mujeres narran la violencia obstétrica en primera persona' (*El Desconcierto*, 30 January 2018) <www.eldesconcierto.cl/2018/01/30/dijo-que-si-nos-gusto-abrirnos-aguantaramos-ahora-mujeres-narran-la-violencia-obstetrica-en-primera-persona/> accessed 31 May 2019.

[2] Lucia D'Ambruoso and others, 'Please understand when I cry out in pain: Women's accounts of maternity services during labour and delivery in Ghana' (2005) 5(140) BMC Public Health 5. <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-5-140> accessed 31 May 2019.

[3] Sian Norris, 'When gynecologists gaslight women' (*Newsmavens*, 20 November 2018) <https://newsmavens.com/special-review/914/when-gynecologists-gaslight-women> accessed 31 May 2019.

[4] Osservatorio sulla Violenza Ostetrica Italia (OVOItalia), 'Violenza ostetrica in Italia: ora abbiamo i dati autorevoli' (2017) <https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/> accessed 31 May 2019.

or vilifying mistreatments in the context of childbirth, be it before, during or in the aftermath of it; 21%[5] report experiencing some form of violence. In the last 10-15 years, the quality of care during childbirth has occupied increasing space in the public discourse, largely due to the worldwide press and the activism of a network of organised civil society movements in different countries,[6] who have worked to raise awareness and have advocated for the human rights of birthing women to be respected. As a consequence of such activism and lobbying, some states have even introduced new legal terms in order to protect women's rights in childbirth; however, the international community has done little in this respect.

In this context, pain is part of what might cause childbirth to be traumatising and demeaning, as the quotes above clearly show. The issue of pain and its relief during childbirth, nonetheless, have been paid relatively little attention to. While pain relief is often readily available and provided, when it is requested and the medical staff deems it safe to administer it, I have heard and read of too many women whose pain in childbirth was ignored, or demeaned, or even situations in which they were mocked or scolded for speaking up about it. While the international human rights framework provides instruments to protect birthing women from a wide array of mistreatments, the issue of pain is harder to redress.

This thesis stems from the observation of this problem: there is a need to regard childbirth as a moment where women's rights are especially at risk of being violated, and in this context, the presence of pain is crucial and yet too often its relevance is neglected or minimised. More attention must be given to the reasons why this is so – which, as I will discuss, are to be found in gender as an oppressive societal order.

This thesis, therefore, aims at raising and examining the issue of pain in childbirth: first, by unpacking the meanings of pain, especially when it is experienced by women in the context of childbirth; secondly, by articulating pain relief in childbirth as a human right, to be recognised and granted through a solid legal foundation and through a shift in how society conceives it. My hypothesis is that the current lack of attention

[5] OVOItalia (n 4).

[6] In the last ten years, non-governmental organisations (NGOs) to monitor the quality of maternity care have been set up, among others, in Chile, Italy, Greece, Croatia, Argentina, Spain and Brazil.

to pain in childbirth is due to how constructions and imagery of maternity and femininity are embedded into political, legal and medical institutions, thus contributing and perpetuating discrimination and oppression.

The methodology I have used to carry out this analysis is necessarily multi- (or better yet, inter-) disciplinary: 'the unique position of childbirth at the nexus between medical ambitions, gender-based discrimination and social perception of motherhood and femininity demands that it be approached with careful consideration for its multi-dimensional aspect'.[7] This approach guided the methodology of this entire work. I have resorted to the lens of gender studies in order to examine issues of bioethics, religion, sociology and law, in order to make visible the patterns of oppression and power that underlie the social relations happening in pregnancy and childbirth.

The first chapter explores what shaped the current status of pain in childbirth in society, and why it is seen as irrelevant or otherwise often ignored. I will go through social, cultural and religious contexts, which together lay a foundation for medical habits and attitudes which are all too often consolidated in healthcare facilities.

In the second chapter, I will go through the legal panorama in which pain relief is located; I will summarise the human rights instruments available and applicable to guarantee pain relief in general, and more specifically, in childbirth. In this context it will appear clear that there is a legal void on this subject.

The third chapter, therefore, will embark upon the discussion of a hypothetical framework in which pain relief in childbirth can be defined and addressed as a human right: first, I will show how the denial of pain relief in childbirth constitutes a form of gender-based violence (GBV); secondly, I will provide a definition of obstetric violence as subsuming the notion of GBV and, as such, as a potentially effective device to address the lack of legislation concerning pain in childbirth. I will also stress the importance of education on human rights and gender awareness: this is necessary to address the root of the problem and to draw attention to the structural reasons why pain in childbirth is often minimised and neglected.

[7] Véronique Bergeron, 'The Ethics of Cesarean Section on Maternal Request: a Feminist Critique of the American College of Obstetricians and Gynecologists' Position on Patient-Choice Surgery' (2007) 21(9) Bioethics 478.

Little attention has been given to the cultural, social and political implications that come into play when it comes to the women's reproductive sphere (pregnancy and childbirth). But it is exactly these implications that enable us to explain why childbirth and pain are 'managed' as they are. This thesis aims at unveiling exactly this aspect, with the objective of making it easier to foster a change which is not only formal, but substantial, involving society at all levels.

Pain relief in childbirth should be regarded as a universal human right, and although no legal framework – and consequently, case law – has been developed so far in this respect, I will explore the ways in which it could be implemented, while attempting at unveiling the structural social, cultural and religious reasons which explain this situation.

# 1.

# PREGNANCY AND CHILDBIRTH, PAIN AND HUMAN RIGHTS

## 1.1 A PUBLIC MATTER

'As the mechanism by which society reproduces itself, pregnancy is by no means a private matter, but is peculiarly susceptible to social intervention and control.'[8]

To this day, the only way human beings can come to life is through a human womb,[9] which entails, in the great majority of cases, that the person whose body the womb belongs to is a woman. Thus, pregnancy and childbirth are what enables human life to be reproduced and, being specific to female bodies, a significant event in a woman's life.

These events have been trapped by the institutional net of society for many reasons; they, we must remember, are not simply biological events, but have always been meaningful rituals of passage, deeply social experiences, and ultimately, a public matter, with endless significant implications and 'profound bodily and existential meaning'.[10] This must be kept in mind when it comes to analysing the norms and laws that regulate pregnancy and childbirth and, in general, the reproduction of human beings.

To be able to trace the relevance of the issue of pain in pregnancy and childbirth within the realm of women's rights, we first need to step back and define these two bodily events, especially as far as modern Western

[8] Clare Hanson, *A Cultural History of Pregnancy. Pregnancy, Medicine and Culture, 1750–2000* (Palgrave MacMillan 2004) 6.

[9] Ectogenesis, ie the gestation of a human being outside a womb, is not yet technologically viable, although research is allowing for more progress in this direction. This will entail, of course, medical, legal and ethical challenges which go beyond the purpose of this thesis.

[10] Anne Drapkin Lyerly, 'Shame, Gender, Birth' (2006) 21(1) Hypatia 101.

society[11] has conceived and understood them. This chapter aims at elaborating definitions of pregnancy/childbirth and their relationship with pain from different perspectives, to give an account of how complex and multifaceted the discourse about it is: I will analyse the ontological features of pregnancy, as well as frame it and its connection to pain from a medical, religious, social and cultural point of view.

After this theoretical introduction of the subject matter, I will illustrate four main situations in which pregnancy, pain and human (reproductive) rights of women are crucially intertwined, as an example of how the issue of pain and human rights influences profoundly different contexts of pregnancy and, especially, childbirth: these are a) natural childbirth, b) caesarean (also referred to as c-section), c) surrogate motherhood and d) abortion. Such an excursus will allow me to demonstrate how pain in the female body is a constant factor in human reproduction, with different philosophical, social, cultural and even political meanings, depending on the nature of the pregnancy and of the delivery.

Finally, I will explore the link of pregnancy and childbirth to the reproductive rights of women, trying to briefly describe the human rights implications that these experiences involve – and how the discourses and connotations attributed to pregnancy and childbirth influence their treatment on the part of society, institutions and law. This will serve as a foundation to discuss in depth, in chapter 2, the legal instruments that international human rights law currently provides.

## 1.2 The (ab)normality of pregnancy

'Constructing the natural is a political act, since within the notion of the natural are assumptions about what power is and how to access it.'[12]

When investigating pain during pregnancy and childbirth, it is interesting to shed light on the very nature of these phenomena first. In fact, the presence of pain gains a different meaning when we analyse how the whole process of conceiving and bearing a child is perceived.

[11] The reason why I have selected Western conceptions is that it is in this context that much of the scientific knowledge which has now arisen to a global level was first constructed.

[12] Pamela E Klassen, 'Sacred Maternities and Postbiomedical Bodies: Religion and Nature in Contemporary Home Birth' (2001) 26(3) Signs 775, 801.

For a mother, pain is one way or another a *conditio sine qua non* for the beginning of a new human life – as Julia Kristeva puts it:

> one does not bear children in pain, it's pain that one bears: the child is pain's representative and once delivered moves in for good. Obviously, you can close your eyes, stop up your ears, teach courses, run errands, clean house, think about things, about ideas. But a mother is also marked by pain, she succumbs to it. 'And you, one day a sword will pass through your soul.'[13]

To explore their link with pain, I am going to discuss whether and how these events have historically been normalised – that is, how they have been labelled and taken for granted as an integral part of a woman's reproductive life – and how the standards of normality and abnormality have been interplaying with pregnancy, childbirth and female reproductive and sexual behaviour during this socially relevant moment of transition to a (potential) new life. Before continuing, we need to keep in mind that the term 'normal' used when referring to childbirth and pregnancy is a multifaceted one. Therefore, I will now try and give a brief account of its slippery and complex implications.

The question here appears to be: 'is pregnancy really normal?',[14] and moreover, 'when is it that pregnancy is (not) normal? What conditions allows us to discern a normal pregnancy from an abnormal one?' Firstly, 'normal' is opposed to 'abnormal' in that the normal status of a human body, if men are the point of reference, is that of being non-pregnant. Therefore, if a healthy male body is not pregnant, a female pregnant body is clearly deviant from the male standards and pregnancy can be read as an illness, something which has a course and for which the cure is its resolution, be it through childbirth or through abortion.

Secondly, starting from a different assumption – that pregnancy is not an illness but an event in female reproductive life – 'normal' could refer to a pregnancy which is free from 'abnormal' traits or episodes, and that therefore needs no intervention other than assistance in delivery and requires no particular medical attention – what is defined as normal or abnormal is, of course, the result of widely shared norms and standards produced within a community of knowledge in a specific time and place.

[13] Julia Kristeva and Arthur Goldhammer, 'Stabat Mater' (1985) 6(1/2) Poetics Today, The Female Body in Western Culture: Semiotic Perspectives 133, 138.

[14] Warren M Hern, 'Is Pregnancy Really Normal?' (1971) 3(1) Family Planning Perspectives 5.

Thirdly and conversely, from the definition of pregnancy as a 'normal' status for a woman we can infer that 'not being pregnant', and not bearing children, would be the abnormal condition for a female body, created exactly for the purpose of reproducing human life. This view stems from a physiological/biological and essentialist assumption, according to which the nature of the female body is inclined to bearing children and to motherhood. This definition of pregnancy and childbirth has a fundamental relation with the use of the word 'normal' as a synonym of 'natural', which in turn raises interesting questions, as we shall now see. From this association, it appears that the natural state of a woman is that of being a mother, and that pregnancy is a condition for a full, realised femininity – notably, women who do not conceive have historically been labelled as 'barren'.[15]

On the other hand, this concept of 'state of nature' recalls the notion of the Illuminist view of the 'good savage': in this framework, women/mothers' sexuality is subjugated to their main function in life, that is, to bear their offspring and reproduce: in this perspective, it is easy to frame these events as primal processes, almost 'animalistic, so that basic animal instincts are included in the childbirth process'[16] and that women are literally equated to wild animals, the ones who are able to access the most primordial dimensions of life, but also the ones who are relegated to that stage, as opposed to a more intellectual, rational one.

Literature is replete with these stereotypes, which come back now and again in more or less explicit ways, even in the contemporary ideology of the 'natural birth' advocacy, which we will discuss later. Suffice to say that, according to the views of the 18th-19th century, the 'pampered' women living in cities and conducting a wealthy lifestyle were 'spoilt' and 'barren', while the 'state of nature' women bred many children and were seen as being more fertile, closer to the natural function of women[17] as if anything that took women away from nature also detached them from what was seen as their natural function, namely childbearing and

[15] Hanson (n 8) 10. Another view purported by Warren Hern is that, instead, 'pregnancy has traditionally been defined in Western culture as "normal", and the desire to terminate the pregnancy therefore, as, "pathological"', stating that only childbirth would be the 'abnormal' phase, while pregnancy would be the ordinary, non-pathological stage.

[16] Mirko Prosen and Marina Tavčar Krajnic, 'Sociological Conceptualization of the Medicalization of Pregnancy and Childbirth: The Implications in Slovenia' (2013) 43(3) Revija Za Sociologiju 251, 261.

[17] Klassen (n 12) 782.

childrearing. Inasmuch as women are conceived as 'lower', instinctual creatures, closer to the animal reign that to the humane, rational one, it is interesting to point out that even the way they embody and externalise the experience of pregnancy and pain is filtered through this underlying assumption: as demonstrated by Esther Cohen in her analysis of the perception of human pain in history, women have long been seen as more inclined to be vociferous about their physical pain than men,[18] as if their 'animal side' placed the display of their pain on a different evaluation scale.

There is a tension between nature as women's vocation for responding to the call of biology, thus fulfilling societal expectations, and on the other hand, nature as a potentially evil force governing the process of human reproduction: nature has to be understood, dominated and tamed, lest we are to face dangerous, potentially deadly consequences both for the pregnant woman and for the foetus. While society often holds onto the gender stereotypes discussed above, it also seems willing to take control of the processes which derive from them: in modern society, the means by which this control is enacted is technology within the realm of the medicalisation of pregnancy and childbirth. As Mirko Prosen and Marina Tavčar Krajnic remarked, modernity has internalised the idea that nature can – and must – be overcome, or at least harnessed, by technology.[19] Tellingly, in the Western world the great majority of births still happen in a hospitalised context where medical technology monitors and leads the phases and pace of childbirth.

While we cling to the view of pregnancy as women's highest, most 'normal' function, at the same time 'Western medicine has begun treating pregnancy as a specialized kind of illness requiring prenatal care, obstetrical supervision and postpartum follow-up with positive results which the patients themselves recognize and seek out'[20]. Interestingly enough, the way patients feel about medicalisation changes from culture to culture, once again intertwining pregnancy and childbirth with what is conceived as natural or as deserving medical attention in different cultures: since the 1960s, in the West, especially in the United States of America (US) and in Europe, we have witnessed the

[18] Esther Cohen, 'The Animated Pain of the Body' (2000) 105(1) The American Historical Review 36, 38.
[19] Prosen and Tavčar Krajnic (n 16) 252.
[20] Hern (n 14) 6.

self-described "movement for natural birth", which strongly opposes the medicalization of pregnancy and childbirth, in favour of "natural childbirth", whatever that term entails for its advocates; in the global South, meanwhile, women tend to trust medical intervention and surrender to the knowledge-power of the medical class more than their Western counterparts.[21]

The widespread medicalisation of pregnancy and childbirth results in a process through which 'non-medical problems become defined and treated as medical problems, usually in terms of illnesses and disorders';[22] while discussing it, we should not forget that, just as the standards defining normality and abnormality are socially constructed, science and technology are part of a 'particular cultural production and representation'.[23] Ann Oakley goes even further when she equates science to an ideology,[24] reminding us once again that norms and standards are specific to a particular historical, social and cultural context and not universal and ever-lasting. Considering this notion, medicalisation can also be understood as a means of taking control of a process which has traditionally inspired awe and fear, a way of institutionalising it and making it less threatening and more predictable. In fact, reproductive processes have been the core interest of organised human groups in that society expands and grows through them, giving way to the widely shared and internalised idea that 'pregnancy and childbirth should be supervised both medically and legally, that it has become unacceptable for people to decide about these – now medical matters – themselves, that de-medicalization of pregnancy and childbirth would in some way be a threat to the social order'.[25] This assumption has given way to and consolidated the trope of the female body as something 'construed as uncontrollable, uncontained, unbounded, unruly, leaky and wayward'[26] to be tamed through technology as a tool for social control. Technology

[21] Candace Johnson, 'The Political "Nature" of Pregnancy and Childbirth' (2008) 41(4) Canadian Journal of Political Science/Revue Canadienne de science politique 889, 893; George A Skowronski, 'Pain relief in childbirth: changing historical and feminist perspectives' (2015) 43 (History supplement) Anaesthesia and Intensive Care 27.

[22] Peter Conrad, 'Medicalization and Social Control' (1992) 18 Annual Review of Sociology 209.

[23] Ann Oakley, 'A Case of Maternity: Paradigms of Women as Maternity Cases' (1979) 4(4) Signs - The Labor of Women: Work and Family 607, 608.

[24] ibid.

[25] Prosen and Tavčar Krajnic (n 16) 256.

[26] ibid 255.

takes over the process of childbirth and directs it, instead of the birthing woman: Warren Hern points out that even in obstetric manuals, 'the subjective feelings and symptoms of the pregnant woman receive only cursory attention in comparison with other, more technical details'.[27]

As has been mentioned, medicalisation is often seen as opposed to – and conflicting with – 'natural' pregnancies and births: feminist scholars, among which Barbara Katz Rothman,[28] have called for a more 'natural' pregnancy and birth experience, which should allow women to feel more empowered and less dependent of external knowledge and power than in the medicalised context, while some[29] argue that the problem is not medicalisation per se, but rather, the power structure and between genders in which pregnancy and childbirth are treated and in which discourses on women's reproductive processes are created. Birthing women's attitudes towards the topic have been ambivalent as well, with some supporting the 'natural childbirth' discourse against what is seen as a monopoly of institutions over physiological processes, and some firmly believing in the medical establishment's ability to manage their pregnancies and births.[30]

It is not the amount of technology or medicalisation that is important, but rather the discursive interpretation and conception of pregnancy, childbirth and the pain linked to them, and how its meaning has been dragged through centuries as part of a stereotype influencing 'patterns of socialization'[31] – which, as I shall illustrate in the next chapters, is mirrored in legal texts as well. Here, I follow Laura Purdy's view in claiming that the problem is not the act of medicalisation itself, but how it relates to subjectivity, to agency, to autonomy: the underlying 'current culture of medicine'.[32] Relevantly, Oakley stated that such a 'culture' is necessary in society to 'fit reproduction into the category of human concerns in which doctors can exercise and enforce their

[27] Hern (n 14) 7.
[28] Barbara Katz Rothman, 'The Social Construction of Birth' (1977) 22(2) Journal of Midwifery and Women's Health 9, 13.
[29] Drapkin Lyerly (n 10) 101.
[30] Ellen S Lazarus, 'What Do Women Want? Issues of Choice, Control, and Class in Pregnancy and Childbirth' (1994) 8(1) Medical Anthropology Quarterly, New Series 25.
[31] Drapkin Lyerly (n 10) 101.
[32] Laura Purdy, 'Medicalization, Medical Necessity and Feminist Medicine' (2001) 13(3) Bioethics 249, 250.

jurisdiction'.[33] From here, the notion of the 'illness of pregnancy'[34] gains deeper meaning and a wider relevance at a social, cultural and even political level.

As a part of the assimilation of women's reproductive life into the realm of the medical and the pathological is the notion of pregnant women as affected by illness, thus interpreting their behaviour as the assumption of the 'sick role', a sociological concept which assumes that a subject convinced to be ill will act as if he – or she, in this case – was in need of extra care and attention, exactly as a sick person would. In her research on the sick role among pregnant women, Myra Leifer notes that, unsurprisingly, it is the emotional response to their status which leads to 'the view of female patients as deviants (…), an integral part of the medical ideology in which women are defined as ill by virtue of their reproductive functions, held responsible for what is disabling'.[35] The dichotomy takes place between normality considered as 'health' or, in narrower terms, 'sanity' (especially mental, as we shall now see), and disease: women's bodies and minds have long been seen as victims of their biology, especially in that their uterus undergoes monthly changes which are more visible and politically significant[36] than any changes that the male body goes through – thus, attributing a 'sick role' to pregnant women eases the relationship between pregnancy and childbirth and psychological disease, thus 'gendering mental instability'.[37] These associations bear dangers which might take shape in the relationship between health professionals and pregnant or birthing women by undermining the humane and dignified experience of childbearing; Leifer rightfully observed that 'the persistence of the belief that pregnancy-related symptoms are of psychogenic origin has resulted in their being treated inadequately or with derision by medical personnel'.[38]

[33] Oakley (n 23) 609.

[34] Hanson (n 8) 60. Myra Leifer observed how the condition of being visibly pregnant often causes women to be socially stigmatised, and even to be treated as 'women are socially stigmatized for being visibly pregnant and that reactions to pregnant women very closely parallel those to the physically disabled' (see Myra Leifer, 'Pregnancy' (1980) 5(4) Signs - Women: Sex and Sexuality 754).

[35] Leifer (n 34) 758.

[36] Hanson (n 8) 37.

[37] ibid. The correlation between women and psychological instability was endorsed by the international scientific community for decades: tellingly, the very term 'hysteria' comes from the Greek *hysterion*, meaning 'uterus'.

[38] Leifer (n 34) 757.

The issue of pain in pregnancy and childbirth becomes crucial in this framework: as the experience of pain is inherently individual, when the patient experiencing it is perceived as mentally or emotionally unstable, her pain could easily be belittled or ignored as a token of this instability or lack of endurance. This is unfortunately not uncommon in medical hospitals around the world, leading to gross violations of women's rights in pregnancy and childbirth in what has come to be defined as obstetric violence; institutions such as the Committee of the Convention on the Elimination of Every form of Discrimination Against Women (CEDAW) and the World Health Organization (WHO) are addressing increased attention on this normalised but diffuse phenomenon, with interesting developments.

These observations allow us to conclude that, while the medicalisation of pregnancy does decrease the risk of maternal and foetal death, at the same time it potentially places pregnant and birthing women in a subordinate 'sick role', whether they have internalised it and recognised it as theirs or not. Once again, we are faced with the ambivalence of pregnancy and childbirth: pregnancy is treated and diagnosed as a sickness, but pregnant women who act as if they were sick are regarded as performing 'a sick role'. 'Pregnancy is regarded as "normal", yet it is treated in practice as a specialized form of illness. This may be regarded as an example of cognitive dissonance', observed Hern.[39]

In this view, the 'ambivalent organic condition of pregnancy'[40] becomes clearer: there is a thin line between normal and abnormal, healthy and sick, sane and insane, powerful and vulnerable, rational and irrational: historically, pregnancy and childbirth have been located on the edge of these opposing realms, placing pregnant and birthing women in a culturally malleable position where stereotyping and mystification play a significant role. In fact, on one hand, childbearing is perceived as the highest function that the female body can perform, as an empowering event, something bringing authoritativeness, a new awareness, even the condition for a 'completed' femininity; on the other hand, a pregnant woman is 'the victim of nature', someone who, under an incontrollable psychological and physical turmoil, changes completely her ways and becomes overridden by emotions. The same

[39] Hern (n 14) 45.

[40] William R Rosengren, 'Social Sources of Pregnancy as Illness or Normality' (1961) 39(3) Social Forces 260, 267.

ambivalence has been noted by Deborah Rogers[41] in other fields related to female reproductive life: 'bearing children and continuing a male line are enshrined as women's greatest achievement, even as exercising their sexuality is punished by the pain of pregnancy and domination'. Here, the dichotomy is between a virtuous behaviour, ie good motherhood, and a vicious one, ie sexual intercourse: the mere fact of experiencing female sexuality, even in the context of a monogamous relationship, might lead a woman to pregnancy and, therefore, to the punishment of pain, observes Rogers.

These categorisations are part of how society has constructed and perpetuated gender roles: according to Oakley, 'just how reproduction has been socially constructed is of prime importance to any consideration of women's position. It may even be in motherhood that we can trace the diagnosis and prognosis of female oppression'.[42]

Adrienne Rich[43] supports this view by claiming that 'patriarchy could not have survived without motherhood and heterosexuality in their institutionalized forms': indeed, they have been used for ensuring property passage and for legitimating social order, linking 'the female(physical) economy and wider social structures'.[44] Further, pregnancy and childbirth have become social acts precisely because 'society is threatened by the disorder of what is beyond its jurisdiction. The cultural need to socialize childbirth impinges on the free agency of women who are constrained by definitions of womanhood that give maternity an urgency they may not feel'.[45]

It is now clear that pregnancy and childbirth are phenomena of collective interest, to which societies have attached meanings, values, symbols and protocols of control; pain is involved in this collective elaboration as well, as it constitutes an inevitable feature of these two events. Significantly, Pamela Klassen takes Pierre Bourdieu's notion of *habitus* to describe the process in which '"society (is) written into the body, into the biological individual" and works to structure actions and

[41] Deborah D Rogers, 'Rockabye Lady: Pregnancy as Punishment in Popular Culture' (1992) 26(1) Journal of American Studies 81, 83.
[42] Oakley (n 23) 608.
[43] Adrienne Rich, *Of Woman Born. Motherhood as experience and institution* (WW Norton & Company 1995) 43.
[44] Hanson (n 8) 51.
[45] Oakley (n 23) 608.

beliefs while making them appear natural'[46] – one more time, the term 'natural' appears to indicate the normative, the commonly accepted. Therefore, just as pregnancy and childbirth do, pain, too, has multiple cultural connotations and values, and its very notion and definition is socially determined. In the next sub-chapter, I will discuss how culture, religion and morality interact with one another in the construction of pain in pregnancy and, especially, childbirth.

### 1.3 From nature to culture: issues of pregnancy and pain

In this study of pain, we will focus on the event of childbirth, since it is in this moment that it is strongest and most present, and where most narratives and discourses on pain related to women's reproductive lives have focused. The fact that childbirth pain has always appeared so ineluctable and inevitable has led cultures to try and find an explanation for its presence and its acuteness: why is it that women are put under such physical torture to give birth? Why do women go through such hell,[47] while men potentially have no contact whatsoever with the experience of pregnancy and childbirth? These questions have put the female body at the core of a wide, never-ending debate where all components of a culture came into play, making it a contested site of knowledge where narratives and norms have been written, unwritten and rewritten to this day. Such narratives have fed and consolidated cultural gender stereotypes – positive and negative ones. They can be found at the roots of virtually every value or meaning attributed to pain in pregnancy and childbirth: as Leifer has observed, 'no other stage in a woman's life is as replete with cultural stereotypes as pregnancy. Indeed, attitudes toward pregnancy have been one of the most prevalent sources of discrimination against women'.[48]

The main and most common cultural stereotype is that of woman as 'the childbearer', also purported by different religions as a woman's destiny, or the will of God.[49] A woman's body undergoes pregnancy

[46] Klassen (n 12) 781.
[47] Words of one of the interviewees in Lynn Callister's study in Journal of Obstetric, Gynecologic, and Neonatal Nursing (2004) on women's perception of childbirth pain.
[48] Leifer (n 34) 754.
[49] Rebecca J Cook, 'International Human Rights and Women's Reproductive Health' (1993) 24(2) Studies in Family Planning 73.

and labour pains as the 'precious deposit'[50] of a child, being the only sex able to literally bring life to earth. In this view, the whole burden of perpetuating humanity rests upon women's shoulders – or better yet, upon their wombs; a woman's value is assessed based on her becoming a mother, implying that she will have to bear through the pains of labour. The stereotypical motherhood role in Western societies is often portrayed as morally and emotionally virtuous capable of great love and sacrifice for the sake of her children and her family: the pains which her physical body has to endure are part of the process through which she will become this mythical figure, embodying a morally elevated function. Women become entitled to be such only thanks to their reproductive tasks – they earn their position in society through the endurance of the burdens of pregnancy and pain.

At the same time, however, a mother is a woman, and as such – at least in Western societies – she will have to adhere to aesthetical standards which require her to keep the physical signs of motherhood invisible, since they would make her less palatable to the eye:[51] in this view, the physical pains of childbirth could be interpreted as the beginning of a painful process of decay, a threshold beyond which a woman's body is no longer deserving of attention or dignity. In the quicksand of ever-changing social codes and norms, the stereotypes on women melt with the ones on motherhood, originating complex networks of meaning which I will try to disentangle.

In doing so, I cannot but resort to religion to make sense of the discourses on pain in childbirth. Here, I refer mainly to Christianity and to Judaism; while stereotypes sprung from religious texts, norms and rituals might certainly be common in different religions around the world, 'we must not forget that the Western scientific and cultural apparatus has been built with strong ties to Christianity, one where women where not the subject, but rather the object of discourses and prescriptions'.[52] Christianity, in turn, stemmed from Judaism, which also presents interesting elements of analysis when it comes to women's reproductive lives. Moreover, as Kristeva observed, Christianity offers

[50] Hanson (n 8) 25.

[51] Nora Doyle, 'Writing the Body. The Work of the Body in Women's Childbearing Narratives' in *Maternal Bodies: Redefining Motherhood in Early America* (University of North Carolina Press 2018) 108.

[52] Klassen (n 12) 775.

'the most sophisticated symbolic construct in which femininity, to the extent that it figures therein – and it does so constantly – is confined within the limits of the Maternal';[53] this also helps shed light on the origin of the cultural stereotypes discussed above – the 'ideology of the sacred motherhood'. Religion is also responsible for turning the sexual aspect inherent to pregnancy and childbirth into a sin – this is crucial if we consider that women are hit by stereotypical discourses, both as females and as mothers.

At this point, it is worth stepping back briefly to be able to widen our perspective. It has been mentioned that the ever-present causal connection between childbirth and pain is its relation to sex. Not only is sex central to the whole representation of female identity – so much so that:

> woman's sex comes to be seen as more essential to her nature than man's sex is to his. We are more likely to see woman as ruled by the whims of her reproductive system than man is by his; more subtly, if no less dangerously, we are simply more likely to think of and be concerned with reproductive issues when thinking of women than of men.[54]

Sexual activity is also the core of millennia of stereotypes, norms and taboos, which put the woman's sexual life at the centre of public scrutiny – her body becomes 'a social text in which sexuality is made visible'.[55]

In this light, pain happens inevitably as the necessary consequence of a woman having sexual intercourse and, even worse, possibly enjoying it: it appears as 'a particularly appropriate punishment since the "crime" or causality is unambiguous'.[56] Again, we witness some degree of ambivalence in that on one hand the human female must be punished for not restraining her body from human passions, while on the other, the same body has to experience sexuality in order to embody her reproductive functions.[57] To solve this tension, notes Kristeva, birth acts as a mending act: a woman is only deserving of salvation to the extent to which sexual intercourse leads to a new life being brought to light; the child is born to 'suture the wounds'[58] of a previous sin.

[53] Kristeva and Goldhammer (n 13) 134.
[54] Margaret O Little, 'Why a Feminist Approach to Bioethics?' (1996) 6(1) Kennedy Institute of Ethics Journal 1, 2.
[55] Rogers (n 41) 83.
[56] ibid.
[57] Hanson (n 8) 57.
[58] Kristeva and Goldhammer (n 13) 149.

When associating childbirth pains with sin, one cannot but recall the notorious 'Eve's curse': the Old Testament has left a heavy mark on how childbirth pain is regarded by society. Although the Bible's notorious verse 'in pain thou shalt bear your children' has been labelled as controversial in the process of its translation,[59] it is indisputable that a whole religious and cultural tradition has been – and still is – borne out of its most widely shared meaning, heavily influencing what the Christian West has thought of pregnancy and childbirth. 'I will make most severe your pains in childbearing', reads Genesis iii 16. What is even more relevant is that the Hebrew word for 'conception' (later interpreted more widely, as 'childbearing') is extremely close to the words 'pain' and 'anger' (or, more precisely, 'divine wrath'), allowing for two different consequences of the original sin: the first one, 'in pain you shall bear children', the second one 'your urge shall be for your husband and he shall rule over you'.[60] These two conditions, that Christianity understands as essential to women's nature in that they derive from Eve's sin, have weighed upon millennia of pregnancies and births, permeating Western culture on many levels.

The silver lining of Eve's epiphany after breaking the law of God is her contact with 'the bittersweet fruit of the knowledge of good and evil':[61] thanks to this newly acquired awareness, through childbirth's pains Eve and her daughters become active participants to the process of creation, thus emulating God's role in creation. In a visionary essay on motherhood and its embodiment, Kristeva has defined on female pain as 'the masochistic foundation of society', elevated to be 'a structural stabilizer – countering structural deviations – and, by assuring the place of a mother in an order that surpasses human will, provides her a reward of pleasure'[62] – the pleasure of holding the power of creation in her womb.

To attain this condition, though, women still have to come into contact with the original sin, hence becoming impure: the discourse on purity is also a constant presence around childbirth, and impurity related to birth is widespread among the monotheistic religions. According

[59] Tzvi Novick, 'Pain and Production in Eden: Some Philological Reflections on Genesis III 16' (2008) 58(2) Vetus Testamentum 235, 237.
[60] ibid 238.
[61] Tammy Ditmore, 'The Pains of Natural Childbirth: Eve's Legacy to Her Daughters' (2008) 16(2) Leaven 70.
[62] Kristeva and Goldhammer (n 13) 150.

to the Jewish Torah, for example, the reason why women suffer and, potentially, die in childbirth is that they have disrespected religious norms on menstrual and postpartum purity rituals.[63] The female body can be as impure as sin and at the same time attain the purity of holiness, and it does so through the very same act, that is, becoming pregnant and giving birth.

Once again, pregnancy, childbirth, and even the value of pain present a high degree of ambivalence, which makes it complex to fully understand these phenomena; Rich gives a comprehensive account of this aspect of ambivalence when she notes that the female body is both 'impure, corrupt, the site of discharges, bleeding, dangerous to masculinity, a source of moral and physical contamination', and 'beneficent, sacred, pure, asexual, nourishing',[64] fitting once again the stereotype of the idealised, sacred, archetypal motherhood. The common association between sex and impurity, sanctioned by pain as a result of a sin, has a twofold consequence: on one hand, the rise of an interiorised sense of guilt and/or shame due to the awareness of the sin; on the other, the notion of pain as atonement, as purification of sexual guilt – analogous to Kristeva's aforementioned concept of birth as the suture of a wound.

In their study on the nature of pain from the middle ages to the 20th century, Carolyn Corretti and Sukumar Desai note that, according to scholars and theologists of the middle ages, pain was explained as the divine punishment for moral transgressions such as sex.[65] Remarkably, since the middle ages, pain has been gendered: women's experiences of pain have been much more dealt with, both verbalised and normalised, than men's.[66] Cohen carried out the same analysis: it is in this epoch, especially with Augustine's philosophy, that the notion of pain as a sign of sin is first consolidated. Childbirth pains were the evident sign of a sinful soul – in fact, 'labor pains were punishment for Eve's crime and therefore ought to be patiently borne. The Virgin, free of all sin, did not suffer any pains during the birth of Christ'.[67] But this pain, though

[63] Christopher R Hutson, '"Saved through Childbearing": The Jewish Context of 1 Timothy 2:15' (2014) 56(4) Novum Testamentum 392, 393.
[64] Rich (n 43) 34.
[65] Carolyn Corretti and Sukumar P Desai, 'The Legacy of Eve's Curse: Religion, Childbirth Pain, and the Rise of Anesthesia in Europe: c. 1200-1800s' (2018) 4 Journal of Anesthesia History 182.
[66] ibid 183.
[67] Cohen (n 18) 45.

originated from sin, was the price for redemption: it could reach a praiseworthy value – much later, in a letter to his wife, Martin Luther would write about childbirth pains 'if you die you die happily, fulfilling the tasks that God has conceived for you'.[68] In this view, women's suffering was not only natural and unavoidable, but became something to wish for, associating all women to the myth of the Christian *Mater Dolorosa* whose cries 'were for the glory of God Father' and whose 'pain, like love, is embedded in the ideology of motherhood'.[69]

Pain was then the means to raise to a Christ-like status, elevating women's souls – the downside of this vision was that a woman who did not suffer, or was not ready or willing to do so, did not really experience mother love. This paradigm fed the conviction that a 'good birth' is a painful one, otherwise, it might mean that the mother 'did not want the child bad enough',[70] leading birth to be a moment of potential self-consciousness, insecurity and self-questioning childbirth pain and its management come with the burden of centuries long stereotypes: 'women (…) bring to the birthing room (…) a complex experience of subordination, and an elaborate repertoire of stereotyped gestures appropriate to their station'.[71] The experience of pain on the part of women, however, is not necessarily perceived as something humiliating, disempowering or belittling: some authors[72] have observed how some women see a link between pain endurance and their own physical and psychological strength, or even a fundamental condition for a dignified, empowering birth – 'birth junkies', as Katherine Beckett defines women who advocate for this view on the experience of childbirth pain, are 'indicative of a kind of machisma *(sic)*, a belief that birth is an extreme sport'.[73] In her review on women's perspective on childbirth pain, Karin Martin found that pain was seen, more often than not, as a 'war pin' which some women see as a necessary rite of passage and feel that without it they could be 'less good mothers', as if pain was the proof of

[68] Corretti and Desai (n 65) 185.
[69] Rich (n 43) 168.
[70] Susan Bordo, 'Are Mothers Persons? Reproductive Rights and the Politics of Subjectivity' in *Unbearable Weight. Feminism, Western Culture, and the Body* (University of California Press 1984) 86.
[71] Drapkin Lyerly (n 10) 115.
[72] Bordo (n 70); Klassen (n 12); Karin A Martin, 'Giving Birth Like a Girl' (2003)17(1) Gender and Society 54; Katherine Beckett, 'Choosing Cesarean. Feminism and the politics of childbirth in the United States' (2005) 6(3) Feminist Theory 251, 257; Drapkin Lyerly (n 10).
[73] Beckett (n 72) 260.

the capacity to surrender the self for another life that is coming to light. In this view, selflessness is part of an 'internalized sense of gender'[74] which sets the standard of how pain should be dealt with by birthing women, largely without their awareness.

In this framework, it is interesting to give a brief overview of the perception on pain relief by birthing women themselves. Anaesthesia during birth was first practiced in 1847, in a time when a 'secularization of pain'[75] was finally taking place: this implies that pain shifted from being conceived as religious necessity to appearing as a 'societal burden, destructive and pointless';[76] since then, various methods have been implemented, but the constant debate has been the interplay between pain relief and women's experience of agency (or, on the contrary, passivity) during labour.

Starting from the assumption that labour pain is a significant part of a woman's power of enacting her feminine identity, pain relief constitutes an 'oppressive liberation', putting women in a passive condition where they cannot be real subjects of their own childbirth. From another perspective, however, such 'passivity' might be exactly what birthing women wish for, as was the case in the 'twilight sleep' advocates in the early 20th century.[77] Pain relief is also regarded differently depending on cultures, just as the display and the expression of pain. Studies[78] have shown that in Western cultures, championed by the US, pain is

[74] Martin (n 72) 54.
[75] Corretti and Desai (n 65) 183.
[76] ibid 184.
[77] Victoria Vivilaki and Evangelia Antoniou, 'Pain relief and retaining control during childbirth. a sacrifice of the feminine identity?' (2009) 3(1) Health Science Journal <www.hsj.gr/medicine/pain-relief-and-retaining-control-during-childbirth-a-sacrifice-of-the-feminine-identity.php?aid=3647> accessed 25 March 2019. Twilight sleep was a method of delivery employed in the early 20th century in the United States of America and in Europe, which consisted of using a mixture of morphine and scopolamine so as to lead the woman into an unconscious state, where nonetheless her body was responsive to uterine contractions, thus allowing for a painless delivery. Its use was interrupted in the 1960s, after its dangerous side effects were discovered. Women's movements supported its use and so did obstetricians, who defended it since it gave 'absolute control over your patient at all stages of the game (...) You are "boss"' (J Walzer Leavitt, 'Birthing and Anesthesia: The Debate over Twilight Sleep' (1980) 6(1) Signs, Women: Sex and Sexuality, Part 2 147, 160). Clearly, anaesthesia in childbirth lays on a thin line between progressive liberation and subjection in disguise (Rich (n 43) 171). It is interesting how even the passivity provoked by the altered status induced by anesthesia was linked to a religious/moral sphere, in that passivity in suffering was meritorious, recalling of the Virgin Mary or Christ (Rich (n 43) 128).
[78] See for example Lynn C Callister, 'Cultural influences on pain perception and behaviors' (2003) 15(3) Home Health Care Management and Practice 207; Nastaran Beigi and others, 'Women's experience of pain during childbirth' (2010) 15(2) Iran J Nurs Midwifery Res 77.

considered as something pathological, and therefore extremely negative, to be avoided as much as possible; consequently, its display – and its medical relief – are widely accepted, while in Eastern societies, such as Korea, pain is perceived as an element inherent to childbirth and a deeply intimate experience, which one wishes to be able to endure with no external help and to keep for herself, lest she will dishonour her family.[79] In any event, the mere possibility of detaching the experience of excruciating pain from the experience of giving birth was decisive in reshaping women's and society's views on childbirth and childbearing in general;[80] pain has always characterised the deeply physical experiences of pregnancy and childbirth, but the secularisation and medicalisation of the link between them deeply changed social and cultural perceptions.

### 1.4 Different births, same pain?

After an excursus on the nature of pain in pregnancy and childbirth and its position within society, we can now embark upon the discussion on how different types of birth are influenced and characterised by pain in diverse and yet similar ways, with interesting common grounds.

The first situation I will examine is what has commonly been known as 'natural' childbirth, ie vaginal childbirth[81] as opposed to caesarean section. It is useful to consider these two births together or, better yet, in contrast with one another, in that a woman's choice (or obligation to) one over the other carries relevant implications for the meaning attributed to childbirth pain, both for birthing women and for society. During natural childbirth – hereinafter 'vaginal delivery' – the woman is awake, more or less actively engaging in labour: in this case, unlike in C-sections and abortions, it is not only her body, but also her mind which are taking an active part in the process, and not only dealing with its preparation or its aftermath.

This means that the whole array of notions and ideas learnt by the woman through her socialisation, experiences and education come

[79] Nastaran Beigi and others (n 78) 80.
[80] Doyle (n 51) 206.
[81] The term 'natural childbirth' can assume different meanings: it can refer, in its narrowest conception, to the lack of any medical intervention whatsoever, or, on the other extreme of the spectrum, to any medical manoeuvre insofar as the birth takes place through the vaginal canal. These two notions of 'natural' include a whole array of in-between situations. For the purposes of this chapter, I will use 'natural childbirth' with its widest implication.

together to shape and make meaning of labour pain. As Victoria Vivilaki and Evangelia Antoniou point out, 'during labour the woman is dealing not only with the contractions, but also with the myths that the culture has created for her'.[82] Nancy Lowe[83] and Lynn Callister[84] also stress this point, stating that culture and social schemes are influential not only in the perception, but also in the expression of labour pain. The origins of the moral burden of pain in pregnancy and childbirth into which all women are socialised has been widely discussed in the previous section of this chapter: therefore, I will focus not on the meanings of this pain, but rather on its influence on women's perceived experience based on these meanings.

Pain is, in general, a deeply subjective experience with no universal description; pain in labour is just as subjective and every woman might voice it or face it in a different way, but as Corretti and Desai point out, it is not a universal given: in fact, it 'can be viewed as a construction shaped largely by societal institutions, beliefs, values, and standards'.[85] Indeed, as has been mentioned before, some cultures allow or even endorse its vocal expression, while others might consider it as inappropriate for something which is simply a given and cannot be avoided or mitigated by expressing it.[86] Interestingly, women seem to agree on the fact that the intensity of pain is made more tolerable by the awareness that it is going to be a 'productive pain':[87] the birth of a child seemingly helps birthing women put into perspective their pain and endure it with no medical relief even when it reaches excruciating levels, 'for a greater good'.

At the same time, though, labour pain is often interpreted as something without which a woman loses the right to her femininity and identity as a good mother, which raises doubts about the narrative of pain relief-free narrative by defining this type of delivery as pervaded by the 'oppressive monopoly of pain'.[88] Kelly Madden and others[89] solve the dichotomy

[82] Vivilaki and Antoniou (n 77).
[83] Nancy K Lowe, 'The nature of labor pain' (2002) 186(5) The American Journal of Gynecology and Obstetrics 16.
[84] Lynn C Callister, 'Making meaning: Women's birth narratives' (2004) 33(4) Journal of Obstetrics, Gynecology, and Neonatal Nursing 508.
[85] Corretti and Desai (n 65).
[86] Callister (n 84).
[87] Vivilaki and Antoniou (n 77).
[88] ibid.
[89] Kelly L Madden and others, 'Pain relief for childbirth: The preferences of pregnant women, midwives and obstetricians' (2013) 26 Women and Birth 33.

between the 'with-or-without-pain-relief' labour by shifting the medical staff's and the women's attention away from the 'pain relief paradigm' and towards the 'working with pain paradigm', which suggests that women should be in a position where they are able to 'labor through' their pain without feeling helpless and obliged to accept medical relief, but without feeling powerless and humiliated if they do decide to resort to it.

Moreover, pain should not always be equated to suffering, as they might overlap but do not identify with each other: while pain is something physical and, at least to a certain extent, unavoidable, suffering is rooted in the whole experience of childbirth and depends both on the physical sensations and on the emotional/psychological status of the birthing woman. Lowe[90] observed that, if the woman knows the origin of her pain and is aware and confident of the resources at her disposal in order to cope with the pain and overcome it, suffering is not necessarily coupled with this pain, which in turn comes to be 'a healthy sign' of a successful childbirth.

Coping with pain seems to be the biggest challenge in vaginal delivery: not only from a physical point of view, but also – and more importantly because this is the only dimension that can be consciously influenced – from a psychological point of view: pain has been proven to be perceived as stronger and harder to overcome when a woman is in a state of loneliness, anxiety, worry, or has low self-worth.[91] While pain is always present as part of the childbirth process, excruciating pain can be mitigated or managed in different ways and should be the focus of both medical staff and birthing women who challenge themselves to endure pain in the name of the greater good.

In the case of caesarean section, the active engagement of the woman is removed; pain is still present, but it happens *as a consequence* of the event, and for this precise reason it takes up new and different meanings than in 'natural' childbirth. To make sense of the relationship between C-section and pain, we need to distinguish situations in which women deliberately choose it from the ones in which women are forced to undergo such treatment, be it for medical reasons or because of routine or medical habits – a C-section might not only be recommended, but also practiced by

[90] Lowe (n 83) 22.

[91] Rebecca H Allen and Rameet Singh, 'Society and Family Planning Clinical Guidelines Pain Control in Abortion part 1 – Local Anesthesia and Minimal Sedation' (2018) 97 Contraception 471.

default in many clinics and hospitals, such as Brazil, to the point where it is widely recognised as the 'normal' way of giving birth. It has been pointed out[92] that this tendency might be of concern, in that it represents one of the results of an acritical medicalisation of pregnancy and childbirth, where technology literally takes over the process and becomes the subject of it, leaving a marginal role to the birthing woman and depriving her from the agency she would otherwise be able to enact.

In this case, pain is the logical result of a surgery, and literature shows less connections with discourses on moral, religion, sex, sin and guilt than in the case of vaginal deliveries. However, if it is elective, ie it is the woman who chooses caesarean over 'natural' childbirth, the meaning of pain acquires a different relevance. When famous Spice Girl Victoria Adams chose to give birth to her first child through a C-section, she was promptly labelled by the press as 'too posh to push', a phrase which gained success and is nowadays widely used as an idiom to refer to a woman who decides not to undergo labour and the pain linked to it by opting for a C-section. This phrase makes clear how deeply society has assimilated the idea that pain has to be a feature of childbirth, and how the unwillingness to endure it remains a sign of bad motherhood – Candace Johnson has remarked how a woman who chooses a C-section is perceived as only trying to 'skip the hardship by choosing the easy way out, when instead, as a woman, her task is to go through suffering, and as a mother, her duty is to deliver the baby to the world through natural childbirth'.[93]

To be sure, the quantity of pain between labour and C-sections can depend on a variety of factors, which makes the decision of giving birth through C-section to avoid labour pain somewhat ill-founded. The choice of avoiding natural childbirth in order to avoid the excruciating pain associated to it can surely be empowering, and possibilities of alleviating pain should always be made available; however, even what looks like a free choice can actually be the result of internalised schemes of inferiority and powerlessness by pregnant women, thus revealing the 'pattern of domination living beneath the veneer of autonomy'.[94] Such patterns can become more or less visible in pregnancy and childbirth, but the way pain

[92] Claudia Malacrida and Tiffany Boulton, 'Women's Perception of Childbirth Choices: Competing Discourses of Motherhood, Sexuality, and Selflessness' (2012) 26(5) Gender and Society 748.

[93] Johnson (n 20) 908.

[94] Bergeron (n 7) 479.

is perceived and treated – both by birthing subjects and by medical staff – makes them more explicit. Pain can be a weapon of oppression, and the techniques to relieve it, the monopoly of the procedures to control it, or the knowledge about its origins and its dynamics are all tools embedded in a wider discourse and belonging to a certain type of knowledge and power relationship.

The mistreatment of pain, or the lack of attention to it, can represent human rights violations, like the aforementioned phenomenon of obstetric violence. This analysis allows us to affirm that pain, both in vaginal delivery and in C-section, is framed in a wider context of meanings and symbols: these two types of birth are representative of two opposing attitudes towards what is regarded as 'proper', 'safer' or 'more dignified'. However, it must be emphasised that 'both extremes are socially constructed as both empowering and oppressive'.[95]

The connotations of childbirth pain have to be interpreted within a wider framework, where childbirth does not belong only to birthing women,[96] and where decisions over its management do not depend exclusively on their sheer will. Another blatant example of this is the case of surrogate motherhood, where a woman gets pregnant and delivers a child that, by contract, she will not parent. Pregnancy and childbirth are commodified and assessed in terms of economic value; a deeply bodily, subjective experience is the object of a legally regulated transaction in which motherhood and parenthood become detached from one another. It is interesting that the term 'surrogate mother' refers to the person bearing the child and not to the actual surrogate mother, that is, the adoptive parent who will eventually mother him or her. In this case, pregnancy and childbirth are but physiological events with virtually nothing to do with parenthood: 'labour' acquired a twofold meaning, one of which indicates the supply of a service beyond a payment.

In a lawsuit about a surrogate mother changing her mind about giving her baby to the parents by contract, Judge Richard N Parslow stated 'I see no problem with someone getting paid for her pain and suffering (...) They [gestational mothers] are not selling a baby; they are selling pain and suffering',[97] with the strikingly evident equation of pregnancy and labour

[95] Jonhson (n 20) 908.
[96] Bergeron (n 7) 481.
[97] Mary L Shanley, '"Surrogate Mothering" and Women's Freedom: A Critique of Contracts for Human Reproduction' (1993) 18(3) Signs 618, 625.

pain to any other paid labour – which is, ultimately, the rationale behind the whole concept of surrogate motherhood. While some claim that 'contract pregnancy is thus a way to make the assumption of parental responsibilities more gender neutral: it can "soften and offset gender imbalances that presently permeate the arena of procreation and parenting"',[98] I argue that surrogate motherhood does anything but flatten gender imbalances; rather, it stresses them, by underlining the specificity of the female body's experience as a site of commodified labour (in both senses). Resorting to it simply means transferring the burden to another body – that of a woman, to be sure – who will undertake the effort for someone else.[99]

The fact that the surrogate mother is 'freely' choosing to be one does not change this underlying condition of existence of motherhood, which is a deeply gendered matter. In this case, childbirth pain becomes an integral part of a paid work: the gestational mother, who physically bears the burden of pregnancy and labour, receives a reward for deploying a function beyond her control and which she performs with no interruption for months. Pain in surrogacy loses some of the connotations discussed in the previous paragraph: gestation and childbirth are functional to someone who engaged in an economic transaction, and childbirth is not the product of a woman's sexual activity, much less an accidental by-product of it (like in some of the cases of abortion). This deep difference in the origin of pregnancy, which is meant to lead to a 'final product' foreseen by a contract, changes the whole interpretation of both pregnancy and childbirth, and the pain related to them.

Among the four types of birth analysed here, the last is an atypical one: in fact, the reason why it has been considered here is that this study of pain focuses not only on childbirth pain itself, but rather on its meanings, connotations and significance in relation to pregnancy, with all of the implications discussed in the first section of this chapter. When mentioning abortion, here I am referring to voluntary interruptions of pregnancy (VIP), ie medical/surgical abortions, and not to miscarriages – this is to avoid making the scope of this research too wide to be adequately

[98] Shanley (n 97) 620.

[99] The issue of surrogate motherhood, with its connections to pain, on one hand, and to power dynamics related to gender, and often class and ethnicity on the other, brings about the theme of dignity – which, as I will discuss in the next chapter, is at the very roots of human rights, as per the Universal Declaration of Human Rights. To what extent the dignity of a 'surrogate mother' is violated is indeed debatable and makes the issue of surrogacy even more controversial.

dealt with. The discourse on pain in abortion must of course be linked to the issue of preventing a potential life from developing: being such a delicate and potentially traumatic moment in a woman's life, the stress is often on how harmful aborting is for women, thus linking pain to the very choice of having an abortion performed. The rationale tends to be that women who choose to abort have taken the substantial responsibility of carrying a new life and have not been mature enough to bringing it forward – in this perspective, the female body is a vessel for new lives, whose human rights are made less valuable than the ones of the foetus. Moreover, this rationale is blind to the fact that pregnant female bodies embody pregnancy, being united with the foetus, and yet not the same being.[100] To ignore this means interpreting the pain related to abortion as something which is well deserved for someone who deliberately decides to perform a killing by getting pregnant only to later regret it: this exclusively female behaviour will involve serious consequences, among which are physical and psychological pain.

Various studies have demonstrated how, even in the case of abortion, the assistance and proximity of health professionals are crucial to the experience of pain: Rebecca Allen and Rameet Singh[101] have observed how 'anxiety, depression and a woman's anticipation of the pain are strong predictors of the pain she perceives during surgical abortion', suggesting that the presence and comfort of medical staff can, therefore, be helpful in decreasing perceived pain during and after the surgical abortion procedure. The same study has also found that 'pre-abortion counseling can reduce pain by decreasing fearfulness and anxiety'.[102] However, the necessary routine counselling and psychiatric consultation prescribed in many countries to legally have a VIP could lead to significant delays to the procedure, and 'the ritual of bureaucratic procedure and delay (…) may be more painful, anxiety-provoking and threatening to her mental - as well as physical - health than the abortion'.[103]

[100] Shanley (n 97) 625.
[101] Allen and Singh (n 91) 472.
[102] ibid.
[103] Shanley goes on to say that 'Since routine psychiatric consultation is widely recognized, even within the profession, as having practically no medical function in the determination of indications for therapeutic abortion, it must be seen as a legitimizing ritual demanded by society in which the woman acknowledges unsanctioned behavior or thinking and expresses contrition in exchange for both expiation of 'guilt' and safe treatment of her circumstantially self-defined illness of pregnancy': again, female sexual and reproductive health is embedded into moral discourses which are deeply gendered. Shanley (n 97) 625.

Pain due to voluntary abortion is not linked to birth, which makes it a 'non-productive pain', meaning that women experience it without a baby as the final reward justifying it; the pain is also associated with the guilt of having interrupted the development of a new life, which comes from religion and 'morality'. Again, it seems impossible to interpret pain in pregnancy and childbirth in neutral ways, as it would be understood in any other surgical or medical event: it comes written on the female body text, on which words have left their mark for centuries.

### 1.5 Pregnancy, pain and women's reproductive rights

The last section of this chapter gives a brief account of the relationship between pain, pregnancy, childbirth and human rights of women – especially reproductive rights. I start my analysis based on the assumption which underlies the whole chapter, that is, that law does not happen in a sterile vacuum, but is the product of a contamination of social forces and must be so understood, just like the meaning of pregnancy, childbirth and pain. In this light, gender plays a paramount role in explaining the position of women's legal status in many domestic jurisdictions – 'women's legal status often reflects an instrumentalist interpretation of her being', observed Margaret Little.[104]

I am convinced that the analysis in the next chapter cannot but be a feminist one. Only in holding that women's rights are human rights can we shape a fair and dignified legal framework for pregnancy, childbirth and the pain management during them. I argue that treating pregnancy and childbirth as neutral medical events like any other, without considering that, with few exceptions, traditionally it is female bodies who have been at the centre of these phenomena, leads us to missing the main point of protecting women as subjects of human rights. In her review of women's access to reproductive rights, Rebecca Cook has argued that 'the universal risk factor is that of being female':[105] in line with this observation, I consider de-gendering pregnancy as both unfair and dangerous to all women and for the protection of women's rights. In fact, when laws ignore the gender issue, they might perpetuate or create discrimination instead of guaranteeing its elimination. As Rachel Pine rightfully remarked:

[104] Little (n 54) 3.
[105] Cook (n 49) 72.

> At times it seems that the law's ignorance of its actual impact is one of the most severe threats to basic civil liberties. When justice is blind to the fruits of scientific and social research, and to the demonstrable effects of a statute in operation, rules of law are divorced from the empirical world;[106]

an empirical world where gender – together with race and class – determines an individual's conditions and, among other rights, access to health.

An intersectional perspective is necessary to grasp the patterns of power and domination hiding behind women's right violations in pregnancy and childbirth: as observed by Rajat Khosla and others, 'the enhanced risk of human rights abuses in the context of reproductive health care, based on sex and/or gender and such intersecting factors is well documented, and is often referred to as intersectional or multiple discrimination'.[107]

Societal need of control comes with the need to regulate, categorise and define, usually by applying orthodox heteronormativity, in this case to the conduct of the female body. Non-white or lower-class female bodies, who do not usually fit into such heteronormativity, are even more vulnerable to this discrimination: they are 'useful at best, disruptive at worst',[108] in that they disrupt the 'womanly notions of sentimental motherhood'[109] which fits the stereotypes discussed in the previous chapter. Aware of the complex network of meanings, symbols and tropes which hang upon pregnancy and childbirth, Klassen observed that 'the materiality of birth (…) is absorbed and refracted through constructions – for instance, those of gender, race, religion, class, and sexuality':[110] such materiality includes the unwritten norms that govern how birth takes place, and even more relevantly, the written ones, that is, law. When we use intersectionality as a prism to interpret human rights, we are in fact implying a 'very different way to read gender, race, and class (…). That is, not as individual attributes but as structuring relations of power within facility-based practice',[111] as Erdman puts it.

[106] Rachael N Pine, 'Benten v Kessler: The RU 486 import case' (1992) 20 Law, Medicine and Health Care 238, 242.
[107] Rajat Khosla and others, 'International Human Rights and the Mistreatment of Women During Childbirth' (2016) 18(2) Health and Human Rights Journal 131, 134.
[108] Doyle (n 51) 205.
[109] ibid.
[110] Klassen (n 12) 783.
[111] Joanna N Erdman, 'Commentary: Bioethics, Human Rights, and Childbirth' (2015) 17(1) Health and Human Rights.

The mere fact of being a female represents an obstacle in the full enjoyment of the right to health: women's reproductive health has traditionally been at the margins of society's concern, because the threats carried by pregnancy and childbirth were considered as an inevitable stage of a woman's life, in which the stakes are high and so are the risks, but in which women deserve specific attention as carriers of foetuses rather than holders of rights. Cook claims that the foundational reason why this is the case is that:

> women's reproductive health raises sensitive issues for many legal traditions because the subject is related to sexuality and morality. If women could enjoy sexual relations while preventing pregnancy and avoiding sexually transmitted diseases, then, many believed, sexual morality and family security would be in jeopardy. Such traditional morality is reflected in laws that attempt to control women's behavior by limiting or denying women's access to reproductive health services.[112]

Apart from the ever-present interest in controlling and regulating women's sexual and reproductive behaviour for the sake of order and the smooth functioning of social groups, another relevant issue in determining women's degree of access to reproductive and sexual health is subjectivity.[113] Indeed, women tend to be seen as a function of their reproductive task and not as human beings and as rights holders. Legal institutions often embody this assumption by subjugating pregnant and birthing women to norms which do not take into account the centrality of *their* human rights; the core subject, the main rights holder is all too often not the woman, but rather the foetus – or even the woman's partner. As Susan Bordo wrote, a pregnant woman seen as performing the function of a vessel to carry the foetus into the world:

> is supposed to efface her own subjectivity, if need be. When she refuses to do so, that subjectivity comes to be construed as excessive, wicked. (The cultural archetype of the cold, selfish mother – the evil goddesses, queens, and stepmothers of myth and fairy tale clearly lurks in the imaginations of many of the judges issuing court orders for obstetrical intervention.).[114]

[112] Cook (n 49) 73.
[113] Kristeva and Goldhammer (n 13); Shanley (n 97); Drapkin Lyerly (n 10).
[114] Bordo (n 70) 79.

What is negated is, once again, the woman's full subjectivity. Mary Shanley adopts an extremely interesting view by positing the existence of what she calls a 'dyadic relationship'[115] of the woman with the foetus she bears, but also with the partner, the state, the law or the adoptive parents to be (in case of surrogated motherhood). Such dyadic relationship always puts the female body in relation with another subject, which usually enters this relationship from a hegemonic position where the woman's rights are constantly negotiated and contested in favour of another complementary rights holder. During pregnancy and childbirth, women's subjectivity becomes even more problematic not only due to the presence of a foetus (whose rights as a person are often debated), but also because the woman is not in control of what is happening to her body, thus embodying both the subject and the object of pregnancy and childbirth.

Situations in which this became clearly visible can be found in many cases brought to the attention of human rights courts. A blatant example is the case of *Tysiąc v Poland*,[116] before the European Court of Human Rights (ECtHR), in which a woman's bodily and psychological health – and, consequently, her quality of life – were considered by the state and by domestic law to be of less importance than the successful termination of her pregnancy. The ECtHR found Poland to be in breach of article 8 of the European Convention on Human Rights (ECHR)[117], the right to private life. Another example concerning the ECHR is the case of *AK v Latvia*,[118] in which the applicant was denied antenatal screening tests which would have permitted her to decide whether to have a baby or proceed with a voluntary interruption of pregnancy due to the risk of genetic diseases. In *AK v Latvia*, the ECtHR also found a violation of article 8 of the ECHR. Similar cases are found within other regional human rights systems, for instance, the Inter-American Court of Human Rights.[119]

[115] Shanley (n 97) 629.

[116] *Tysiąc v Poland* (2007) ECHR no. 5410/03, ECHR 2007-I.

[117] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 8

[118] *AK v Latvia* (2014) ECHR no. 33011/08.

[119] It is not the aim of this thesis to embark upon a case law analysis, which would nonetheless be enriching in supporting this chapter's argument that women's reproductive rights are all too often overlooked, I argue, due precisely to their being women.

Ultimately, the basic women's rights which should be the foundational ones – the right to non-discrimination and to reproductive self-determination, to begin with – are easily ignored or overlooked, and do not seem so basic after considering the socio-cultural factors that lead to their violation. In many cases, women are prevented from enjoying full sexual and reproductive health as a result of violations of the principle of non-discrimination based on sex, and of many other fundamental human rights, such as the right to education and information (and hence the right to participate in decision-making about their own bodies), and of course, the right to health.

Among the several instruments dealing with and protecting women's health, the CEDAW is particularly relevant in its article 12 on women's health – further fostered in the CEDAW Committee's General Recommendation 24. What is most innovative about the CEDAW, however, is (1) the importance given to the gender perspective in the formulation of the notion of 'non-discrimination': the Preamble significantly states that 'the role of women in procreation should not be a basis for discrimination', and (2) the acknowledgement of gender stereotypes as a contribution to discrimination and inequality. Article 5(a) obliges state parties to:

> modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.[120]

It thus targets all attitudes and treatments which place women in a stereotyped social role or function. Moreover, the CEDAW is the first human rights treaty dealing directly with women's reproductive rights and at the same time addressing 'culture and tradition as influential forces shaping gender roles and family relations'.[121] Other instruments address women's health in a more general, all-encompassing way – among these are the non-binding Universal Declaration of Human Rights (UDHR), the United Nations (UN) International Covenant on

[120] UN GA, 'Convention on the Elimination of All Forms of Discrimination Against Women' (1979) 1249 UNTS 13 art 5(a).

[121] UN, 'Gender Equality' <www.un.org/en/sections/issues-depth/gender-equality/> accessed 25 June 2019.

Economic, Social and Cultural Rights (ICESCR), the UN Convention on the Rights of the Child and many regional instruments. I will further discuss these instruments in the next chapter. Here, I merely aimed at exploring how women's reproductive rights are related to the issue of pain in pregnancy and childbirth, and how law as a product of society comes with strings attached – strings which have been extensively discussed in this chapter.

International human rights law has had a significant role in promoting a new conception of women's reproductive rights as human rights and in encouraging the reform of domestic legislations. Although various studies discussed in this chapter address pain management and regard pain relief as a human right, pain (and more specifically, pain related to pregnancy and childbirth) is hardly mentioned in human rights instruments, as if law did not envision freedom from pain as something a woman can rightfully wish for – or, more likely, as if law rationalised pain as something so embedded in the process of pregnancy and childbirth that it is hard for legal norms to regulate its reduction or elimination. Indeed, the issue of childbirth pain does have consequences targeting aspects of life protected by international human rights, as chapter 2 will illustrate.

## 1.6 Conclusion

This chapter has illustrated the ways in which pregnancy and childbirth manifest a deeply gendered phenomenon, carrying deep social, political and cultural consequences: if men were to give birth, surely the whole society, and the rituals of pregnancy and childbirth would be arranged in a totally different way. In this framework, the value given to pain and suffering in pregnancy and childbirth also has a lot to do with gender, just as the notion of normality, parenting roles and good childbirth do. I am aware that this 'genderedness' brings about problems: by interpreting pregnancy and childbirth through the gender lens, we run the risk of falling prey to essentialist interpretations that validate stereotypes and subordination more than they liberate the pregnant or birthing women; however, as problematic as it can be, gender *is* deeply embedded in these bodily events, even more so when one considers how socially and publicly relevant they are.

To conclude, when embarking upon a discussion of women's rights in pregnancy and childbirth, it is fundamentally important to recognise that they are not merely private matters, and that the pain and the physical burdens involved are not simply individual, but rather become part of the territory of negotiation between different knowledges and powers. The female body is a 'contested space' or 'borderland', where 'the coding of experiences in this space is inherently political, which is to say that it is both constitutive and demonstrative of power dynamics'.[122] In this borderland, compliance and resistance are on a pendulum, in a constant negotiation. Such negotiation, I argue, should eventually lead to pregnancy and childbirth being brought back to where they belong: in the physical and psychological realms of the personal life of women – the very agents of these phenomena.

As long as subjectivity is not at the centre of cultural, political and legal discourse on pregnancy and childbirth (and on the pain related to them), we will be de-humanising them. But it should be remembered that, as Bergeron argued, 'de-humanizing the fundamental experience of childbirth (…) is merely displacing sexism'.[123] In other words, if childbirth is analysed without taking into account the identity of the person giving birth, including her gender, a relevant component will be missed of the very meaning – social, political, cultural, legal – of childbirth and pregnancy.

[122] Johnson (n 20) 905.
[123] Bergeron (n 7) 487.

# 2.

# PAIN RELIEF IN CHILDBIRTH: THE APPLICABLE HUMAN RIGHTS FRAMEWORK

This chapter embarks upon the discussion on the human rights framework on pain relief in childbirth. Indeed, the international instruments – including declarations and reports with no legally binding value – on this issue are few and can generally be placed in the context of the wider notion of dignified maternity care – of which pain relief is but one aspect, often minor and generally ignored, compared to other dimensions such as informed consent or overall birthing conditions, such as hospitalised as opposed to home delivery.

To disentangle the intricate relationship between human rights, the experience of pain (and its relief) and childbirth, I will first discuss the right to pain relief from a more general standpoint, which will reveal how complex the issue is – even when childbirth is not the focus.

As it stands, pain relief can be framed within the wider angle of the right to health, which includes the right not to suffer and, ultimately, is related to the right to be free from cruel, inhumane and degrading treatment, ie torture. In this light, I will review the international instruments and guidelines that the main human rights institutions such as the UN, and regional mechanisms, have issued on the topic, as well as the existing non-binding declarations and guidelines, such as those issued by the WHO.

After discussing the right of patients to be free from pain and suffering – and its translations in legal terms – I will problematise the identity of mothers as patients, which is ambiguous and difficult to grasp in its entirety. To what extent a woman giving birth is a patient, and thus entitled to the same protection as that guaranteed by legal instruments protecting patients' rights, is arguable; consequently, whether we regard birthing (or pregnant) women as patients makes a lot of difference in the amount of legal protection they must be given by law.

From this awareness stems the need to further discuss the right to pain relief in a more specific situation, that is, childbirth. I will explore the legal dimension of pain relief distinguishing two different cases: the pain that is inherent in non-medicalised childbirth, and the pain which is caused by medical procedures. The discussion will be related to the previous chapter, in terms of how much pain we, as birthing women or as medical staff, are legally entitled to avoid, and how these norms are rooted in gendered cultural and societal norms about pregnancy and childbirth.

In this perspective, I will give an overview of the legal instruments available concerning the specific case of pain relief in childbirth: their scarce number and the lack of a focus on women's subjectivity in the framework of pain relief will support the argument that law mirrors an overarching power structure in which gender occupies but an insignificant space.

## 2.1 An international human right to pain relief?

In the last decades, medicine has dedicated increasing attention to the problem of pain and its relief; nevertheless, it has been observed that pain control is, on a general level, 'neglected by governments' attention',[124] that 'the relief of acute pain in medical settings remains more rhetoric than reality',[125] and that 'insufficient pain management is a significant public health concern'.[126] Pain control has been addressed by national and international institutions through various actions and declarations,[127] but, as Scott Fishman observed, to this day 'pain medicine is an orphan within major medicine, fragmented by competing disciplines that would adopt it and unable to gain the recognition necessary to affect systemic change'.[128]

[124] Farnad Imani and Saeid Safari, '"Pain relief is an essential human right": we should be concerned about it' (2011) 1(2) Anesthesiology and Pain Medicine 55.

[125] Frank Brennan, Daniel B Carr and Michael Cousins, 'Pain Management: A Fundamental Human Right' (2007) 105(1) Pain Medicine 205.

[126] Michel Daher, 'Pain Relief is a Human Right'(2010) 11 Asian Pacific Journal of Cancer Prevention - MECC Supplement 97.

[127] ibid.

[128] Scott Fishman, 'Recognizing Pain Management as a Human Right: A First Step' (2008) 105(1) Pain Medicine 8, 9.

From a bioethics perspective, pain relief should be granted by virtue of two basic principles: beneficence (acting for the patient's good) and non-maleficence (acting without harming the patient's health);[129] however, from a strictly legal point of view, to this date no such right as the 'right to pain relief' has been postulated by any international human rights instrument. Reference to pain is made in several WHO guidelines and non-binding instruments – as this chapter will show – but no comprehensive legal regulation can be found; the way pain is dealt with by human rights law is peculiar and complex. Before exploring the legal panorama on pain relief, I will argue that it is important as a human rights issue and also acknowledge the difficulties in implementing it as a 'human right'.

There are several reasons why pain relief ought to be considered, from a medical, political and legal standpoint: first and foremost, it has become clear in the scientific community[130] that pain is not only a consequence or a symptom, but can indeed become a disease per se; moreover, under- or mistreated acute pain can become chronic pain, which has consequences on a physical, social and psychological level,[131] entailing a relevant cost, not only for the individual, but for society and the state.[132] Studies[133] have underlined the negative consequences of non- or mistreated pain: pain becomes a multifaceted problem which requires an interdisciplinary approach.

Pain management and pain treatment, however, have always been problematic on many grounds: in line with the hypothesis laid down in chapter 1, Frank Brennan and others have claimed that the inadequate treatment of pain is often rooted in myths and beliefs which pervade society and the medical field: the 'reasons for deficiencies in pain management include cultural, societal, religious, and political attitudes, including acceptance of torture',[134] even in industrialised countries.[135]

[129] Marko Jukic and Livia Puljak, 'Legal and Ethical Aspects of Pain Management' (2018) 47(1) Acta Medica Academica 18, 21.

[130] Michael Cousins, 'Relief of acute pain: a basic human right?' (2000) 172(3) Medical Journal of Anaesthesia 3; Daher (n 126) 98.

[131] Vincent Boama, 'Overcoming Barriers to Pain Relief in Labor through Education' (2011) 114 International Journal of Gynecology and Obstetrics 207.

[132] Diederik Lohman, Rebecca Schleifer and Joseph J Amon, 'Access to pain treatment as a human right' (2010) 8(8) BMC Medicine 1; Daher (n 126); Imani and Safari (n 124); Jukic and Puljak (n 129).

[133] Marie EC Gispen, 'Poor Access to Pain Treatment: Advancing a Human Right to Pain Relief', Report to the International Federation of Health and Human Rights Organisations (IFHHRO) (2012) 16.

[134] Brennan, Carr and Cousins (n 125) 208.

[135] Lohman, Schleifer and Amon (n 132) 4.

While different authors[136] have posited the existence of pain management as a human right, it has been stressed that, as Marko Jukic and Livia Puljak warned,[137] if we are to treat pain relief as a human right, some issues might emerge which require legislators and advocates to be particularly careful about how such a right is formulated and implemented. An international legal regulation on pain relief could indeed entail unintended consequences, caused by the 'State getting in the way' of matters which might not be best regulated by public entities.[138]

Besides, healthcare staff might be put under institutional pressure by the potential repercussions for the type of pain treatment they choose (not) to administer to their patients.[139] If the human right to pain relief is misinterpreted as a right to 'total analgesia, this will easily lead to frustration among patients and their caretakers and potentially to litigation',[140] as argued by Jukic and Puljak. On the same note, Brennan warned that a right to pain relief and palliative care 'can never mean an absolute right that suffering will never occur':[141] therefore, when advocating for a right to pain relief within the framework of the right to health, we should carefully examine the cases in which such a right can reasonably be claimed, and the limitations it inevitably presents.

If we consider these issues of legal and institutional nature together with pain assessment and the meanings attached to it (extensively discussed in chapter 1), the context in which the human right to pain relief finds its rationale is highly problematic. All in all, Michael Cousins has concluded, 'the adoption of a general view that relief of acute, severe pain is a basic human right, is limited only by our ability to provide it safely in the circumstances of individual patients'.[142] The number of obstacles in the way of a formal recognition of a human right to pain relief will most likely prevent its emergence as a right in and for itself; according to Brennan, Carr, and Cousins, 'for the international

[136] Brennan, Carr and Cousins (n 125); Lohman, Schleifer and Amon (n 132); Jukic and Puljak (n 129).
[137] Jukic and Puljak (n 129) 23.
[138] ibid 22.
[139] Fishman (n 128).
[140] Jukic and Puljak (n 127) 26.
[141] Frank Brennan, 'Palliative Care as an International Human Right' (2007) 33(5) Special article, Journal of Pain and Symptom Management 494.
[142] Michael Cousins, 'Relief from acute pain: a basic human right?' (2000) 172(3) Medical Journal of Anaesthesia 4.

community to consider a Convention on Pain would require both significant advocacy and a paradigm shift in the attitudes of many nations in their public policies related to pain control',[143] which does not seem probable any time soon.

Nevertheless, pain relief has found its way through other positive rights: although the international human rights framework lacks an explicit formulation for the right to pain relief, there can be other ways to enforce it. To be sure, we need to find the root for this justiciability in other long-standing rights, namely, the right to health and the right to be free from cruel, inhumane and degrading treatment, recognised in different instruments at the international, regional and domestic level. The very foundation of a prospective right to pain relief is the principle of human dignity, enshrined in the Preamble of the UDHR, together with its article 25 establishing the right to an adequate standard of living, to which Andrea Solnes Miltenburg and others add three other corollary principles as the foundations of all human rights: these are autonomy, equality and safety – in their view, they are clearly violated in case of failure to provide pain relief to an individual who is suffering.[144]

Moreover, the right to pain relief can be read as included in the right to health, as first formulated in the Preamble of the 1947 WHO's Constitution, which describes health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'[145] and sanctions that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.[146] The notion of health as a comprehensive state of well-being, and the stress on the 'highest attainable' amount of it, allow us to trace a connection between the experience of pain and the lack of a general healthy status and to conceive health as a wider notion than the one foreseen by the 'biomedical model';[147] thus, as mentioned above, pain can be seen as a disease per se, and not only as a symptom or a negligible consequence of what is considered as the 'real' health problem.

[143] Brennan, Carr and Cousins (n 125) 209.
[144] Andrea Solnes Miltenburg and others, 'Maternity care and Human Rights: what do women think?' (2016) 16(1) BMC international health and human rights 2.
[145] Constitution of the WHO, Basic Documents, Forty-fifth edition, Supplement, October 2006.
[146] ibid.
[147] Brennan, Carr and Cousins (n 125) 205.

Since the WHO Constitution, several instruments have recognised the right to health, namely, within the UN, the 1966 ICESCR with its article 12, on which, in 2000, the Committee on Economic, Social, and Cultural Rights (CESCR) issued General Comment No 14, which states that:

> The right to health (…) contains the following interrelated and essential elements (…) availability (…) accessibility (…) has four overlapping dimensions (…) non- discrimination (…) physical accessibility (…) affordability (…) information accessibility (…) acceptability (…) quality (…)[148]

The right to health is also included by other international human rights treaties aimed at protecting the rights of specific categories, such as the International Convention on the Elimination of All Forms of Racial Discrimination (1965)[149], the Convention on the Elimination of All Forms of Discrimination against Women (1979)[150], the Convention on the Rights of the Child (1989)[151], the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)[152] and the Convention on the Rights of Persons with Disabilities (2006)[153]. These instruments recall the right to health as formulated in the ICESCR; the International Federation of Health and Human Rights Organisations (IFFHRO) was also inspired by it when it stated that the right to pain relief must be guaranteed, as it 'stems from the key essential elements of the right to health as outlined by the CESCR'.[154]

Moreover, as mentioned previously, 'it is increasingly argued that the human right to pain relief is reinforced by the prohibition of cruel, inhuman, and degrading treatment' [155] (hereinafter CIDT). The right to

[148] UN CESCR, General Comment 14 on the Right to Health (2000) E/C.12/2000/4.

[149] UN GA 'International Convention on the Elimination of All Forms of Racial Discrimination' (1965) 669 UNTS 195 art

[150] UN GA (n 120) art 12.

[151] UN GA, 'Convention on the Rights of the Child' (1989) 1577 UNTS 3 art 24.

[152] UN GA, 'International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families' (1990) A/RES/45/158 art 28.

[153] UN GA, 'Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly (2007) A/RES/61/106 art 25.

[154] Gispen (n 133) 36.

[155] ibid. See also Jerome W Yates and Rebecca Kirch, 'Regulatory Barriers for Adequate Pain Control' (2010) 11 Asian Pacific Journal of Cancer Prevention - MECC Supplement 17. In this article, the authors affirmed that 'To withhold, impede access to, or delay treatment for severe pain can be considered a form of passive torture that warrants appropriate corrective attention'.

be free from torture is posited in the UDHR's article 5 and enshrined in many international and regional human rights instruments, among which, primarily, the International Covenant on Civil and Political Rights (ICCPR) with its article 7, the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and, in the framework of the Council of Europe, the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (ECPT).

Such a right is part of customary international law and is even interpreted by some as having acquired a *jus cogens* status[156]: on this line, Adrian Van Es added that 'the *jus cogens* character of the right to be free from torture and/or cruel or inhuman and degrading treatment gives the struggle for the right to access to adequate pain treatment urgency and high profile'.[157]

Referring to CIDT and to torture in the context of the denial of pain relief is not unproblematic. For example, Van Es pointed out a problematic side of recognising pain relief as a human right derived from the prohibition of cruel, inhuman or degrading treatment and torture: using what he refers to as 'the torture language' might in fact imply a 'stigma that results from applying the label of "torture" to acts involving medical professionals', which could 'be counterproductive if applied carelessly'.[158] Moreover, the extent to which a state should be considered responsible for private actors, such as medical staff in private healthcare facilities, is unclear. However, it can be argued that state authorities should comply with their positive obligation of preventing acts of CIDT and torture within their jurisdiction, should they be reasonably aware of such acts, as in the case of private medical facilities[159] – ie states should apply due diligence when overseeing the operate of private entities within their territory.

There are many factors coming into play when defining an act – or the omission of it, in our case – as CIDT, which may even result in

[156] Gispen (n 133) 42.

[157] Adrian Van Es, 'Prevention of Torture and Cruel or Inhuman and Degrading Treatment in Healthcare' in S Klotz and others, *Healthcare as a Human Rights Issue. Normative Profile, Conflicts and Implementation* (Transcript Verlag 2017).

[158] ibid 281.

[159] Centre for Reproductive Rights, 'Briefing paper. Reproductive rights violations as torture and cruel, inhuman, or degrading treatment or punishment: a critical human rights analysis' (2010) 11.

torture depending on the degree of vulnerability[160] and powerlessness[161] of the victim. In the case of the denial of pain relief, the person suffering is most likely in a position of vulnerability, which might be increased by other factors such as age, gender and status. Relevantly, two Special Rapporteurs on Torture, Manfred Nowak and Juan Méndez, have each argued, respectively, that 'the de facto denial of access to pain relief, if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment'[162] and that 'intentionally or negligently inflict severe pain or suffering for no legitimate medical purpose. Medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment'.[163]

Other non-binding instruments have also addressed pain relief, but this has been done from a medical and public health point of view and hardly any instruments do so from a human rights perspective. The World Medical Organization, in its Montevideo Declaration on Disaster Preparedness and Medical Response of 2011, has posited that '(…) access to pain treatment for all people without discrimination'[164] is essential, emphasising that '(…) physicians and other health care professionals have an ethical duty to offer proper clinical assessments to patients with pain and to offer appropriate treatment' and that '(…) governments should provide the necessary resources for the development and implementation of a national pain treatment plan, including a responsive monitoring mechanism and process for receiving complaints when pain is inadequately treated'.[165] The International Association for the Study of Pain (IASP), one of the most authoritative international entities working on pain and for pain control and relief, has issued the 2010 Montreal Declaration, which builds upon the human rights treaties previously mentioned and recognises:

[160] UNVFVT, 'Interpretation of torture in the light of the practice and jurisprudence of international bodies' (2011) 2 <www.ohchr.org/Documents/Issues/Torture/UNVFVT/Interpretation_torture_2011_EN.pdf> accessed 06 July 2019.

[161] UN Commission on Human Rights, 'Civil and Political Rights, Including The Questions of Torture And Detention Torture and other cruel, inhuman or degrading treatment Report of the Special Rapporteur on the question of torture, Manfred Nowak' (2006) E/CN.4/2006/6.

[162] UN HRC, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak' (2009) A/HRC/10/44 13.

[163] UN HRC, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez' (2013) A/HRC/22/53 9.

[164] World Medical Organization Declaration on Disaster Preparedness and Medical Response (Montevideo, 2011).

[165] ibid.

> the intrinsic dignity of all persons and that withholding of pain treatment is profoundly wrong, leading to unnecessary suffering which is harmful; (…) the following human rights must be recognized throughout the world: Article 1. The right of all people to have access to pain management without discrimination; Article 2. The right of people in pain to acknowledgment of their pain and to be informed about how it can be assessed and managed; Article 3. The right of all people with pain to have access to appropriate assessment and treatment of the pain by adequately trained health care professionals.[166]

One of the branches of law related to pain relief – and frequently the subject of a lot of government attention, due to its political and economic importance – is the regulation of opioid analgesics. In 1961, the Single Convention on Narcotic Drugs was adopted within the framework of the UN, stating that narcotic drugs are fundamental for pain relief and thus must be provided by governments as needed.[167] Although this field is beyond the scope of this thesis, it is relevant to note that a wide part of the legal and medical literature dealing with pain relief equates access to pain relief with access to opioids; while it is true that the latter undoubtedly constitutes a problem,[168] access to pain relief can be denied, on social and/or moral grounds, even in cases where the necessary drugs are available. Accordingly, the main perceived problem is the war on opioids, which ultimately concerns the circulation and providing of medicaments – but circumstances in which mistreated pain and restricted access to pain relief happen in spite of the availability and readiness of pain relief are far from being extensively explored.

Within Europe, some binding and non-binding instruments can be found which protect the rights of patients, including the right not to suffer: the Declaration on the promotion of patients' rights in Europe (1994), adopted under the auspices of the European branch of the WHO; the Ljubljana Charter on Reforming Health Care (1996, also prompted by the WHO) and the Convention on Human Rights and Biomedicine, adopted in 1997 within the Council of Europe's framework. In addition,

[166] International Association for the Study of Pain (IASP), 'Declaration of Montréal. Declaration that Access to Pain Management Is a Fundamental Human Right' (2010) <www.iasp-pain.org/DeclarationofMontreal> accessed 28 March 2019.

[167] Lohman, Schleifer and Amon (n 132) 2.

[168] According to Lohman, Schleifer and Amon (ibid) 1, as much as 80% of the world population does not have adequate access to pain treatment.

the European Charter of Patients' Rights (the C, was conceived and drafted by a non-governmental organisation (NGO) based in Italy, the Active Citizenship Network. Article 1 of the charter establishes the 'Right to Avoid Unnecessary Suffering and Pain',[169] according to which:

> Each individual has the right to avoid as much suffering and pain as possible, in each phase of his or her illness. The health services must commit themselves to taking all measures useful to this end, like providing palliative treatments and simplifying patients' access to them.[170]

Moreover, article 12 of the charter establishes that 'every individual has the right to diagnostic or therapeutic programmes tailored as much as possible to his or her personal needs',[171] including the need of pain relief, and article 13 states that every patient has the right to complain 'whenever he or she has suffered a harm and the right to receive a response or other feedback'.[172]

While the legal argument for a human right to pain relief can be made starting from the existing right to health, it must be pointed out that, so far, no such right has been explicitly formulated in the international human rights framework. In making the case for a human right to palliative care – to some extent comparable to the right to pain relief and to its application in childbirth – Brennan noted that it is problematic to specify the exact content of the obligations which states ought to observe.[173] However, he argues, the recent developments and connections between health and human rights, and the statements and declarations issued in the last few decades, suggest that an intergovernmental consensus on the topic of pain relief and management is emerging.[174]

This brief review served to illustrate the complexity of guaranteeing a human right to pain relief; on one hand, because of the ambivalent implications of a legal recognition of it; on the other, due to the difficulties of its practical implementation, as well as to the persistence of myths and beliefs which stand in the ways of its realisation. However,

[169] Active Citizenship Network, 'European Charter of Patients' Rights' (2002) art 1 <http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co108_en.pdf> accessed 12 April 2019.
[170] ibid.
[171] ibid art 12.
[172] ibid art 13.
[173] Brennan (n 141) 495.
[174] ibid 496.

the justiciability of this right can be attained through the more general rights to health and from the prohibition of torture and cruel, inhuman, and degrading treatment. An application of such a right would allow for a shift from pain relief as a good practice to pain relief as an imperative.[175] As problematic as it may be, Michel Daher points out, 'pain relief is a public health issue of such critical importance as to constitute an international imperative and fundamental human right';[176] Brennan, Carr and Cousins similarly argued that the 'unreasonable failure to treat pain is viewed worldwide as poor medicine, unethical practice, and an abrogation of a fundamental human right'.[177]

In the case of childbirth and pregnancy, more beliefs and myths are involved, and the dimension of gender enters into play: in fact, as Diederik Lohman and others noted in the case of HIV patients, 'pain treatment is also related to gender, as HIV-infected women with pain are twice as likely to be under-treated as their male counterpart'.[178] Thus, womanhood and pregnancy add layers of complexity to what is an already extremely complex matter. Pain management is currently being addressed across both medicine and law: in the previous chapter I have argued why gender studies is also a valuable contribution as to the reasons why pain control is so problematic, especially in the event of childbirth.

### 2.2 The mother as patient: what relief from what pain?

During the 2004 Global Day Against Pain, held by the IASP in Geneva, it was stated that 'patients have a right to pain management'.[179] Are birthing women also patients? Our next step is to explore the complexities of locating birthing mothers within this category.

In the previous chapter, the complicated definition of pregnancy and childbirth between the realm of health and sickness has been discussed; in virtue of this, the very same problem presents itself when it comes to placing the pregnant/birthing woman within, or out of, the definition

[175] Daher (n 126) 99.
[176] ibid 97.
[177] Brennan, Carr and Cousins (n 125) 209.
[178] Lohman, Schleifer and Amon (n 132) 1.
[179] International Association for the Study of Pain, Global Day Against Pain 2004, Geneva <www.iasp-pain.org/GlobalYear/RighttoPainRelief> accessed 12 April 2019.

of patient. The word 'patient' has its roots in the Latin verb 'patior', meaning 'to suffer':[180] therefore, a patient would be any individual who is suffering and hence is to receive medical treatment to alleviate her or his suffering: starting from this assumption, a woman giving birth with the assistance of medical personnel definitely falls into the scope of this definition, especially given the vulnerable condition that the suffering caused by labour places her in.[181]

However, a person seeking medical treatment usually does so due to the emergence of a disease or some form of sickness, which is not the case for birthing women – unless, of course, birth results in medical complications. As the International Childbirth Initiative (ICI) has stressed, 'Pregnancy, labour and birth are healthy and life-changing *physiologic* processes for most women and their families':[182] what brings a woman to resort to medical assistance is a physiological process; yet, such process puts her in the condition of literally being a *patient*, particularly in the event of a birth taking place in medical facilities, which once again exposes the ambivalent status of a woman at a crucial moment of her reproductive life. Birthing women are an exception causing the detachment of two dimensions – pain and sickness – which not only normally overlap, but are also linked by a cause-effect relationship. Usually, the person who suffers has an illness, and pain is one of the symptoms of something not functioning correctly in the body. A woman giving birth, nevertheless, experiences pain precisely as a sign that the process is occurring according to physiology – although she may even experience pain as the consequence of a problematic birth (or of medical interventions performed during it).

Therefore, during childbirth (and sometimes, in its aftermath, in case of abortion or a C-section), the woman gives birth in a borderland, at the frontier between sickness and full health, at the border of patientness and healthiness. This has interesting legal implications – are birthing women entitled to enjoy and exercise patients' rights? Are they a specific category to be protected and legally framed in another way? Although legally speaking birthing women can be considered as

[180] Brennan, Carr and Cousins (n 125) 208.
[181] Khosla and others (n 107).
[182] The International Childbirth Initiative (ICI), '12 Steps to Safe and Respectful Mother Baby-Family Maternity Care' (2018) 6 <http://intlcb.wpengine.com/wp-content/uploads/2019/12/ICI_12Steps_ENGLISHfull.pdf> accessed 20 April 2019 (emphasis added).

patients,[183] the ambivalent status of a process which is both physiological and medicalised is at the root of the absence of a comprehensive international legal framework of human rights of women in childbirth.

Childbirth is a natural event taking place in a cultured and, in the majority of cases,[184] medicalised context; the human rights approach we are to adopt towards it depends on our conception of this event, whether within or outside medical settings; within or outside the notion of patient. According to the perspective one adopts, the parturient acquires positive rights by being a patient or by virtue of simply being a human being and, more precisely, a woman, entitled to the right to health (and to be free from suffering and violence) during a particularly significant moment in her reproductive life,[185] as per the Office of the UN High Commissioner for Human Rights Factsheet on the Right to Health:

> considering health as a human right requires specific attention to different individuals and groups of individuals in society, in particular those living in vulnerable situations. Similarly, States should adopt positive measures to ensure that specific individuals and groups are not discriminated against. For instance, they should disaggregate their health laws and policies and tailor them to those most in need of assistance rather than passively allowing seemingly neutral laws and policies to benefit mainly the majority group.[186]

It must be kept in mind that non-discrimination is an interestingly complex issue when it comes to dealing with women's rights in pregnancy and childbirth: the absence of a comparable situation in men's reproductive life gives discrimination a different meaning, and the concept of equality has to be interpreted in wider terms if one is to operate it in this context.

On the other hand, if the birthing woman as a subject of human rights is seen as, primarily, a patient, this will also have interesting implications:

[183] See the two Reports (ICESCR and WHO), both mentioning women as patients: UN HRC 'Preventable maternal mortality and morbidity and human rights' (2016) A/HRC/RES/33/18; 'WHO Recommendations: Intrapartum care for a positive childbirth experience' (2018) <www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/> accessed 12/06/2019.

[184] According to OVOItalia, in Italy 99% of women give birth in medical facilities.

[185] Notably, this applies to vaginal childbirth, while in the case of C-sections the notion of woman as patient is less problematic, in that the event of a surgery has a more immediate connection with the 'patient status'.

[186] Office of the UN High Commissioner for Human Rights and WHO, 'The Right to Health. Factsheet No 31' (2008) 11.

the stereotypes and beliefs about pain which have been discussed in the previous paragraph – namely, among others, 'that pain is an inevitable part of the human condition'; 'that pain is necessary, natural and hence beneficial, that pain is essential for diagnosis, that undertreated pain has negligible economic consequences'; 'that severe pain after surgery or in association with cancer is unavoidable and that many patients with chronic non-cancer pain are malingerers or have purely psychologic problems'.[187] These stereotypes led to the idea of 'the good patient' as one who does not 'complain and never challenge(s) health professionals'.[188] Such a stereotype of 'the good patient' could easily interplay with, and reinforce, the stereotype of birthing women as obedient, silent and submissive, thus potentially hindering quality care and attention to pain relief in childbirth. This shows how barriers to pain relief increase in the case of childbirth. In fact, as Daher pointed out, 'apart from regulations and education of medical staff, (they) include patients' attitudes; (…) patients themselves may be reluctant to report pain or to take analgesic medications, particularly morphine'.[189]

The majority of patients 'feel that pain should be relieved, although many also hold concerns about the harmful effects of pain management techniques';[190] however, 'patients actually expect to experience pain in some medical situations or consider that pain management is not a priority with respect to other components of care'.[191] This may be especially true for birthing women, who might interiorise societal attitudes and expectations towards the experience of pain in general and towards pain in childbirth at the same time: in a study on women's expectations towards pain relief in childbirth carried out in Nigeria, Chibuike Chigbu and Tonia Onyeka found that that '79.2% of the interviewed women wished to ask for pain relief in labor but less than half were aware of their right to ask for it';[192] this 'feeds and perpetuates paternalistic attitudes by medical staff, and women end up suffering in silence'.[193]

[187] Brennan, Carr and Cousins (n 125) 208.
[188] ibid.
[189] Daher (n 126) 98.
[190] Amie Steel and others, 'Managing the pain of labour: factors associated with the use of labour pain management for pregnant Australian women' (2015) 18 Health Expectations 1634.
[191] Daher (n 126) 98.
[192] Chibuike O Chigbu and Tonia Onyeka, 'Denial of pain relief during labor to parturients in southeast Nigeria' (2011) 114(3) International Journal of Gynecology and Obstetrics 226, 228.
[193] ibid.

The negative beliefs that are present, in general, around the treatment of pain, are even more powerful when childbirth pain is involved: not only is there a significant lack of training and resources to treat labour pain,[194] but also the application of standards and guidelines on pain relief is prevented by deep-rooted myths and traditions: in the words of a midwife-nurse who was interviewed on how labour pain is normally treated in her medical facility, women 'will go through labour and pain must be there so to deliver a baby, if there is no pain that means, there can't be a baby without pain';[195] another showed awareness of the problem, but helplessness in solving it, explaining that, 'I've not practiced pain relief during labour because we assume that it should be there, and we take it as a normal, of course it's not normal but we take it as if every woman should experience this'.[196]

The belief that pain is necessary in order to perform a correct diagnosis of the progress of labour, or that pain relief can potentially be harmful for the newborn, is still present. In the same study, a midwife states that:

> there is a belief that this pain, we need to know how much pain this patient is experiencing at least at the beginning of the labour to be able to assess and evaluate the progress of labour; the other thing is pain relief can cause harm to babies, they can sedate them, you'll have an inactive baby, you can't use it.[197]

Moreover, the conviction that childbirth is a natural phenomenon (which, in turn, would place women outside of the category of 'patient'?) might lead to the conclusion that labour pain is also natural, and that it 'does not require both pharmacological treatment or management',[198] and anyway it 'must be present and that nothing can be done to relieve [it]'.[199] As for opioids use, it has been found that it is common for healthcare providers to limit its use to women who had a C-section performed, on the grounds that women who had given birth vaginally did not suffer sufficient pain to warrant the use of opioids.[200]

[194] Mary McCauley and others, '"We know it's labour pain, so we don't do anything": healthcare provider's knowledge and attitudes regarding the provision of pain relief during labour and after childbirth' (2018) 18(444) BMC Pregnancy and Childbirth 5.
[195] ibid.
[196] ibid 6.
[197] ibid 5.
[198] ibid.
[199] ibid.
[200] ibid 6.

Placing women in the 'patient position' entails complications which have been pointed out, among others, by the International Childbirth Initiative: as expected 'good patients', women would often be silenced if they are 'too loud'[201] or even offered unwanted medical procedures in order to be silenced, while their 'performance'[202] is often criticised. While automatically considering birthing women as patients could imply more rights protection for them, the other side of the coin might be a focus on providing them with 'a safe' childbirth by providing all technology and interventions possible. Midwives are becoming 'medwives',[203] which could push forward a high amount of medicalisation, with its positive and negative consequences.[204] One of the results of this view of the birthing woman as patient is the triumph of what has been defined by Robbie Davis-Floyd and others as the:

> Western biomedical models of labor and birth 'management'—a traditional, not evidence-based, system that defines the doctor as the expert, the midwives and nurses as his or her expert support team, and the mother as an inexpert patient reliant on authoritative others to generate the successful birth of the baby. This globally dominant model ensures that its practitioners will generally be trained only in the biomedical management of birth and untrained in how to support the normal physiological and psychological process of birth.[205]

As such, 'whilst women are treated kindly and attention is paid to them in this hospital, there is very little respect for the birth process and the physiological nature of this event'.[206] Once again, the thin line between physiological and medical is extremely problematic to define, and so is the application of laws, regulations and guidelines regarding pregnancy and childbirth and the pain relief which is often required during them.

It is interesting to note that most literature – both medical and legal – dealing generally with patient care and pain relief focuses on situations requiring pain treatment which almost never include childbirth. A lot of sources concern opioids and their regulation – especially in the case

[201] Robbie Davis-Floyd and others, 'The International MotherBaby Childbirth Initiative: A Human Rights Approach to Optimal Maternity Care' (2010) Midwifery Today 64.
[202] ibid.
[203] ibid.
[204] See para 4 of this chapter, on obstetric violence.
[205] Davis-Floyd and others (n 201) 13.
[206] ibid.

of chronic pain due to cancer, palliative care, HIV and AIDS or other chronic syndromes, but acute pain, and more specifically, childbirth pain, is not given as much attention.[207] For example, in the article 'Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts?',[208] the authors list a series of situations and disease aspects: HIV/AIDS, cancer, neurological pain (eg trauma, Down's syndrome, epilepsy), surgery and 'other' (eg diabetes, multiple sclerosis, lupus erythematosus), but childbirth is absent from the list. This is often the case in articles on pain relief, which once again shows how birthing women are a peculiar category of patients, and how establishing the legal grounds on which they are entitled to pain relief during childbirth is problematic.

One further element which complicates the position of birthing women as subjects of the right to pain relief is the fact that the pain experienced during childbirth is of a twofold origin: there is the 'natural', physiological pain which is felt during vaginal childbirth, and there is the pain which is caused by medical procedures, such as episiotomy or fundal pressure (both not recommended by the WHO guidelines[209]), as well as post-surgical pain in the case of C-sections.[210] Some of these interventions have been increasingly regarded by the WHO and the CEDAW as unnecessary;[211] the latter even called for 'adequate safeguards to ensure that medical procedures during childbirth are subject to objective assessments of need, and are conducted with respect for women's autonomy and informed consent'.[212]

Starting from the assumption that 'medical care that causes severe suffering for no justifiable reason can be considered "cruel, inhuman or degrading treatment or punishment"',[213] as well as the denial of appropriate care,[214] it could be argued that a human right to pain relief

[207] Fishman (n 128); Gispen (n 133); Yates and Kirch (n 155); Van Es (n 157).

[208] Hans Hogerzeil and others, 'Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts?' (2006) 368 Lancet 305.

[209] WHO Recommendations, 'Intrapartum care for a positive childbirth experience' (2018) 25 <www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/> accessed 12 June 2019.

[210] According to Gispen, 'From a patient perspective, pain distinguishes in disease related pain and treatment related pain' (n 133) 12: notably, childbirth does not fall into either of these categories, not even from a mother-patient's point of view.

[211] Khosla and others (n 107) 136.

[212] ibid.

[213] ibid.

[214] ibid 134.

– and the freedom to refuse it – in childbirth can be identified both in the event of 'natural' labour pain and in the event of pain due to medical procedures or surgeries. However, defining the boundaries of what decisions are to be left to patients (in this case, birthing women) and how much *marge de manoeuvre* medical staff should have further complicates an already intricate issue. Moreover, we are once again confronted with the legal technicalities of equating the denial of pain relief in childbirth to CIDT, or torture.

In fact, of the four elements necessary to define an act as torture (the nature of the act, the intention of the perpetrator, the purpose of the act and the involvement of public officials[215]) the element of the intention of the perpetrator might be arguably missing from the framework,[216] therefore preventing the act of pain relief denial from being defined as torture, or CIDT – luckily, virtually no healthcare professional would deny pain relief to a birthing woman with the intention of causing her suffering.

Nevertheless, as UN Special Rapporteur (SR) Manfred Nowak claimed, it can be argued that when the purpose of the act is clear, then the intention can be implied.[217] One of the purposes relevant for our case is discrimination:[218] such purpose, stated Nowak – and recalled the following SR Méndez in his 2016 report[219] – is always fulfilled if the act can be shown to be gender-specific, as in the case of childbirth.[220] Starting from this assumption, one could argue for the possibility of regarding the denial of pain relief in childbirth as a form of CIDT, and even torture – this view, however, has not been adopted by any human rights tribunal as yet.

When it comes to regulating how much pain relief women giving birth are entitled to receive, these controversial aspects, among many others, must be taken into account. The approach we adopt to frame human rights in childbirth – and more specifically, a right to pain relief

[215] UNVFVT (n 160) 3.

[216] As for the involvement of public officials, the conundrum can be solved, as already discussed, by resorting to the states' positive obligation of preventing human rights violations from taking place in their jurisdiction.

[217] UN HRC, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak' (2008) A/HRC/7/3 7.

[218] UNVFVT (n 160) 4.

[219] UN HRC, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Méndez' (2016) A/HRC/31/57 4.

[220] UN HRC (n 217) 7.

– depends on how we conceive women as rights bearers and the essence of the event of childbirth. Khosla and others rightfully observed that, in order for women's rights in childbirth to be effectively recognised as human rights:

> the right to an effective remedy, among other rights, require the adoption of clear legal and procedural frameworks to ensure the effective delivery of and access to health services. While health system constraints, including lack of resources or services, may create conditions for mistreatment in facility-based childbirth, they cannot be used to justify these actions.[221]

This argument is of vital importance in that, as long as we lack a comprehensive legal framework, it will be impossible to enforce any right to pain relief; so far, the development of norms and regulations on mistreatment of women during childbirth in medical facilities remains at an early stage and only includes a narrow, discrete set of cases[222] in which pain relief is not the main focus. It is clear that 'the range of mistreatment that women may experience has not been adequately addressed or analyzed under international human rights law':[223] such a range of mistreatment could legitimately include the denial of pain relief. Indeed, as I am going to discuss, this is exactly what several NGOs dealing with women's rights in childbirth are advocating for.

### 2.3 How much pain are birthing women bound to bear? Human rights instruments applicable to pain relief in childbirth

The pain women experience while undergoing labour is often described as 'the most excruciating event in their lifetime';[224] women assessing their labour pain through the McGill Pain Questionnaire normally give it a much higher score than the one usually attributed to chronic pain caused by other medical conditions, including cancer.[225] This alone should lead us to recognise that, as Vincent Boama has stated, 'it is (…) extremely important that relief of labor pain is seen as a fundamental human rights

[221] Khosla and others (n 107) 138.
[222] ibid 131.
[223] ibid.
[224] Xian Wang and Fuzhou Wang, 'Labor pain relief for parturients: We can do better' (2014) 8(1) Saudi Journal of Anaesthesia 1.
[225] Boama (n 131) 207.

issue that contributes to safe motherhood'[226] – safe motherhood, that is, is not fulfilled and wholly realised unless childbirth pain is seen 'as a disease entity',[227] given importance to, and relieved.

The problematic definition of birthing women as patients and the gender component of the medical situation complicate the framework in which we work, leading childbirth pain to be often overlooked and/or mistreated, 'for many reasons, cultural, social and religious, ignorance, fear to speak up'.[228] One of the arguments for the recognition of a right to pain relief in childbirth is that its mis- or undertreatment can cause it to turn into chronic pain. Furthermore, mistreatment of pain in childbirth can lead to psychological negative consequences such as 'anxiety, apprehension, long-term emotional stress, post-partum depression, poor maternal-neonatal bonding, and possibly post-traumatic disorder stress'.[229] Moreover, there can be physical consequences both on the mothers and their babies, 'such as maternal hyperventilation, respiratory alkalosis [and] increased cardiovascular load'.[230] These negative developments are especially common in low-income countries, due to 'inadequate human and financial resources for managing pain and because of the contribution of war, poverty, political conflict, lack of political will, lack of clinical leadership, and many other resource limitations'.[231]

The issues of pain in childbirth and its relief are perceived and experienced both by birthing women and by health practitioners involved in the process:[232] the lack, or the low quality, of its treatment does not depend on a sadistic and insensitive medical staff, but rather on various factors[233] – cultural,[234] social, religious, political, financial, legal or contingent – ie directly linked to the immediate circumstances of childbirth, such as the difficulties around informed consent during childbirth. Besides – in case we consider the birthing woman as a patient

[226] Boama (n 131) 207..
[227] ibid.
[228] ibid.
[229] ibid 208.
[230] ibid.
[231] ibid.
[232] Elham Shakibazadeh and others, 'Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis' (2017) 125(8) BJOG 932, 937.
[233] Brennan, Carr and Cousins (n 125) 208.
[234] Pain relief in childbirth is often not prioritised: 'barriers to pain relief for many medical and surgical conditions in the Caribbean include societal perception that pain is unavoidable and a necessary part of life; this perception influences patients and their family's attitudes and expectations'. See Boama (n 131) 208.

– it has to be remembered that patients have no formal right to demand medical treatment, in that 'a medical professional need not, indeed arguably may not, provide treatment that they believe to be harmful to a patient';[235] the entrenched beliefs around pain treatment during childbirth related to a potential harmfulness of (at least some) pain relief methods are quite a powerful hindrance to effective pain treatment in childbirth.

However, the number of options – pharmacological and non-pharmacological – available for relieving pain during childbirth (and after C-sections) should lead medical facilities to provide as many analgesic methods as they can, according to the resources available and the medicaments they can afford. Moreover, it is fundamental[236] that birthing women are given full information about the options available, their consequences and contraindications, and that their informed consent is clear before any pain treatment is administered. Given the numerous obstacles standing in the way of the full realisation of a right to pain relief in childbirth, it has been argued that 'the denial of labor analgesia is an infringement of women's human and reproductive right',[237] and consequently, the relief from labour pain should be included in international binding standards so that these can 'assist health care practitioners and policy makers to define what constitutes mistreatment during childbirth and to develop effective interventions and policies to address this mistreatment in all its forms'.[238]

A human rights approach to women's treatment in childbirth is emerging[239] as a mode of analysis and it has been used – and found particularly effective – to eliminate maternal mortality and morbidity,[240] but pain has not been the focus of legal instruments: neither is it considered as a sign of morbidity, nor is there an explicit right to its relief. However, if we consider that, according to the WHO, 'A human rights-based approach is about health and not isolated pathologies; it is premised upon empowering women to claim their rights, and not

[235] Jonathan Herring and Jesse Wall, 'The nature and significance of the right to bodily integrity' (2017) 76(3) The Cambridge Law Journal 566, 567.
[236] Boama (n 131) 208.
[237] ibid.
[238] Khosla and others (n 107) 138.
[239] Erdman (n 111).
[240] Daher (n 126) 97; Solnes Miltenburg and others (n 144) 1.

merely avoiding maternal death or morbidity',[241] pain relief in childbirth can – just as pain relief in general – be considered as falling into the broader framework of the right to the highest level of health attainable, and a legal foundation for its existence can be found. The 2011 Respectful Maternity Care Charter, issued by the White Ribbon Alliance, also posits dignity, the right to health and the right to be free from cruel, inhumane and degrading treatment (among others) as the fundamental basis of a dignified childbirth.[242]

In fact, while (avoidable) pain might not prevent a healthy baby from being born, ignoring its impact can lead to traumatising births, both for mothers and for newborns: as Khosla and others have claimed, 'though technically sound, care that is lacking in compassion, attentiveness, and *concern for women's needs* and perspectives leaves the patients feeling disempowered, frightened, and alone',[243] which does prevent an unnecessarily painful childbirth from being as empowering and as dignified as possible for birthing women. Starting from this assumption, we can shift the ultimate objective from the elimination of mortality and morbidity to the focus on a respectful, patient (woman)-oriented care, pushing for:

> a turn from the public health world of systems and resources in preventing mortality to the intimate clinical setting of patient and provider in ensuring respectful care (…), beyond ensuring facility delivery to ensuring its quality of care, and moreover, to a conception of quality beyond technical and clinical competence to respectful and humane treatment.[244]

In 2000, the UN Committee for Economic and Social Rights issued the aforementioned General Comment 14 suggesting the creation of a common framework for the development of international human rights standards in health which should include common human rights standards concerning childbirth and pain relief. More specifically, a landmark resolution on the issue of women's rights in childbirth was passed by the UN Human Rights Council, which defined 'preventable maternal mortality and morbidity as a pressing human-rights issue that violates a woman's rights to health, life, education, dignity and

[241] UN High Commissioner for Human Rights. 'Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality', (2012) A/HRC/21/22 2; WHO (n 202) 23.

[242] White Ribbon Alliance, 'Respectful Maternity Care. The Universal Rights of Childbearing Mothers' (2011) 1 <www.whiteribbonalliance.org/respectfulcare> accessed 20 April 2019.

[243] Khosla and others (n 107) 137.

[244] Erdman (n 111) 1.

information';[245] the problem is how pain and its relief interplay with morbidity, and to what extent their management is considered to fall into the realm of human rights in childbirth.

However controversial, and although no self-standing human right to pain relief yet exists – even less so in the specific event of childbirth – the existence of such a right can be extrapolated from other existing rights. In general, as stated by the 2018 WHO Intrapartum Care Guidelines, a right to receive pain relief during childbirth – with all the available and appropriate methods, both pharmacological and non-pharmacological and depending on the woman's preference[246] – can be traced to the context of the right to be 'given timely, appropriate care',[247] and the right not to be 'subjected to mistreatment, such as physical, sexual or verbal abuse, discrimination, *neglect*, detainment, extortion or *denial of services*',[248] which in turn finds its rationale in the assumption that 'every woman has the basic human right to the highest attainable standard of health care without discrimination or maltreatment'[249] – in short, in the right to health.

Moreover, the WHO guidelines stress the importance of women's dignity during childbirth ('health care staff treat all women with kindness, compassion, courtesy, respect, understanding and honesty and preserve their dignity'[250]), thus establishing a connection between the process of making informed decisions to the values of both dignity and autonomy.[251] This entails, with respect to pain relief, that 'women are free to complain without fear of repercussions'[252] and 'all women can make informed choices about the services they receive, and the reasons for interventions or outcomes are clearly explained'.[253] The rationale is that 'it is essential that women feel involved in their treatment and care and can make informed choices in order to improve their compliance and satisfaction with the treatment'.[254] The WHO guidelines, however, are not binding, which significantly limits their effectiveness as a human rights instrument.

[245] UN Human Rights Council, 'Resolution 11/8. Preventable maternal mortality and morbidity and human rights' 2009.
[246] WHO, 'Standards for Improving Quality of Maternal and Newborn Care in Health Facilities' 48 <www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en> accessed 12 June 2019 (emphasis added).
[247] ibid 38.
[248] WHO (n 246) 38.
[249] ibid.
[250] WHO (n 246) 48.
[251] Khosla and others (n 107) 137.
[252] WHO (n 246) 48.
[253] ibid.
[254] ibid 49.

As for binding instruments, at the international level, no specific foundation for the right to pain relief during childbirth can be found, apart from the already mentioned right to health (contained in the ICESCR and in different regional instruments, in some cases with a focus on gender, such as in the African system) and the right to be free from cruel, inhuman, or degrading treatment, or torture (also included in regional treaties as well as the ICCPR, as previously discussed). The CEDAW Committee prompted state parties to realise the right of women 'to be fully informed, by properly trained personnel, of their options in agreeing to treatment (…) including likely benefits and potential adverse effects of proposed procedures and available alternatives':[255] it underlines the importance of non-discrimination in health settings and the importance of eliminating gender stereotyping in its article 5(a),[256] but the fundamental role these play in the treatment of women during childbirth and in how labour pain relief is regarded is still left unexplored.

Both the UN SR on Health and the SR on Torture have recognised women's reproductive rights as a focus of interest, especially within medical settings:

> the UN Special Rapporteur on Health recognised the doctor–patient power dynamic, noting that states must protect the right to autonomy over medical decisions as a counterweight to the imbalance of power, experience and trust inherently present in the doctor- patient relationship.[257]

This is even more imbalanced in cases where the patient is a woman; the UN SR on Torture Méndez, on his part, included the mistreatment of women during reproductive healthcare in his 2013 report on torture and ill-treatment in health care settings. Nevertheless, even though the report mentions both reproductive rights violations and the denial of pain relief (in general) as contexts of interest for his mandate, it fails to explore the interaction between pain and childbirth and the denial of pain relief in that specific situation.[258]

[255] UN CEDAW Committee, 'General Recommendation No 24 on art 12 of the Convention' (1999).

[256] United Nations General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women (1979) 1249 UNTS 13 art 5(a).

[257] Clara O'Connell and Christina Zampas, 'The human rights impact of gender stereotyping in the context of reproductive health care' (2018) 444(1) International Journal of Gynecology and Obstetrics 116, 118.

[258] UN HRC (n 162).

Within the European framework, a foundation for a human right to pain relief in childbirth could be found by inferencing from different rights established by the ECHR (under the auspices of the Council of Europe) and the European Charter of Fundamental Rights (within the European Union) on various grounds: the right to, once again, health and freedom from torture, the right to private and family life (chronic pain can definitely prevent the enjoyment of such right); the right to freedom of expression and to information (if we consider the right to pain relief as linked to the right to receive information about her health); the right to be free from violence; as well as the right to bodily autonomy.[259]

As for international and national NGOs working on the issue of pain relief in childbirth, various guidelines, declarations and reports have been issued in the recent years: for example, Amnesty International[260] has pointed out how even high-income countries have neglected the provision of dignified, respectful maternal care. The International Federation of Gynaecologists and Obstetrics has drawn public attention to 'specific stereotypes that can lead to conduct that contravenes both ethical and human rights standards, namely that women are vulnerable and incapable of reliable or consistent decision- making'[261] and 'that they will be subordinate to men such as fathers, husbands, brothers, co- employees and doctors'.[262] The International Childbirth Initiative, already mentioned several times, has issued a document in which pain relief is seen as an aspect of a safe, dignified and respectful birth. Finally, the White Ribbon Alliance, uniting NGOs working on the issue of maternal care and human rights in childbirth, has strengthened awareness and divulged information on the state of the problem of the denial of care, including pain relief.[263]

Even if the instruments and guidelines these institutions have issued are not legally binding, they do show an increasing interest on the part of multiple stakeholders – both patients and health practitioners –

[259] Herring and Wall (n 235) 577.

[260] Amnesty International USA, 'Deadly Delivery. The maternal health care crisis in the United States of America' (2011) <www.amnestyusa.org/files/deadlydeliveryoneyear.pdf> accessed 15 May 2019.

[261] O'Connell and Zampas (n 257) 117.

[262] ibid. A focus on gender stereotyping and its role in fostering gender-based violence will be given in chapter 3.

[263] White Ribbon Alliance (n 242) 1.

towards improving overall birthing conditions at a global level. Pain relief must be addressed and legally guaranteed if we are to advocate for and protect the highest health standards possible during pregnancy and childbirth.

## 2.4 Conclusion

This chapter has shown how problematic it is to identify and define the legal grounds for a human right to pain relief in childbirth. One of the factors which complicate the issue is the fact that labour pain is an acute pain which is (usually) not linked to any pathological condition, although it is undeniably extremely severe; it comes with cultural and social strings attached its meaning, and the same strings influence the demand for its relief and the use of pain relief itself on the part of health providers; moreover, pain is a deeply subjective experience which is almost impossible to assess from the outside. The legal reasons – including public regulations on the use of opioids, the lack of a specific, self-standing right to pain relief, the issue of informed consent and the definition of birthing women as patients – concur with cultural and social factors and make it hard to find a comprehensive way to deal with pain relief in childbirth.

Whereas some human rights instruments, both international and regional, are applicable to situations concerning pain relief in childbirth, the actual status of pain relief as a human right and its relationship with the aforementioned rights is all but straightforward for the reasons discussed so far; the institutions which have dealt the most extensively with this legal gap have been, so far, international and national NGOs – whose instruments are, of course, not binding.

# 3.

# A PROSPECTIVE SCENARIO

## 3.1 The denial of pain relief in childbirth as a form of gender-based violence

One interesting way of handling this thorny issue is by considering the lack of, or the mis-, treatment of pain in childbirth as a form of GBV. To unpack the grounds of this argument and its implications, I am going to step back first to define GBV and the shapes it can take according to international and regional human rights instruments.

The CEDAW included GBV within the wider framework of discrimination based on gender, with the Committee's General Recommendations 19 and 35.[264] The former defines GBV as 'violence which is directed against a woman because she is a woman or that affects women disproportionately' and, as such, 'is a violation of their human rights',[265] which in turn is included by the concept of discrimination as defined in article 1 of CEDAW: 'Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of Article 1 of the Convention'.[266]

In the European framework, the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention, 2011) also states, inspired by the

[264] The prohibition of gender-based violence against women has evolved into a principle of customary international law thanks to these General Recommendations. See UN CEDAW, 'General Recommendation No. 35 on gender-based violence
against women, updating general recommendation No. 19' (2017), 2.
[265] UN CEDAW, 'General Recommendation No 19: Violence against women' (1992).
[266] ibid.

CEDAW, that '"gender-based violence against women" shall mean violence that is directed against a woman because she is a woman or that affects women disproportionately';[267] similarly to the CEDAW, according to the Istanbul Convention:

> 'violence against women' is understood as a violation of human rights and a form of discrimination against women and shall mean *all acts of gender-based violence that result in, or are likely to result in*, *physical, sexual, psychological or economic harm or suffering to women*, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[268]

Moreover, several human rights instruments[269] have highlighted how GBV, especially in the form of a violation of sexual and reproductive rights, can, in certain circumstances, amount to torture. SR on Torture Méndez stated in his 2016 Report that:

> The purpose and intent elements of the definition of torture (A/HRC/13/39/Add.5) are always fulfilled if an act is gender-specific or perpetrated against persons on the basis of their sex, gender identity, real or perceived sexual orientation or non-adherence to social norms around gender and sexuality (A/HRC/7/3). Gender-based discrimination includes violence directed against or disproportionately affecting women (A/47/38). Prohibited conduct is often accepted by communities due to entrenched discriminatory perceptions while victims' marginalized status tends to render them less able to seek accountability from perpetrators, thereby fostering impunity.[270]

While the ill-treatment of birthing women – including the treatment of the pain they are experiencing – does not imply that medical staff are acting 'with purpose and intent' in order for women to suffer, the fact that such ill-treatment is suffered by them uniquely draws attention to the fact that not only is this phenomenon gender-specific (which is quite obvious, given that men do not normally give birth), but also that the way pain in childbirth is handled comes from women's gender and position in society. Medical staff who are responsible for denying pain

[267] Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence - Istanbul Convention (2011) ETS210, art 3(d).
[268] ibid. (emphasis added)
[269] Special Rapporteur on Torture, CEDAW (n 259), UN 1993 Declaration on Violence Against Women.
[270] UN HRC (n 219) 4.

relief are of course not acting out of sadism, but out of wrong beliefs or medical and education which does not regard pain relief as relevant, much less as a human right of women in childbirth.

After discussing how violence against women, as one form of GBV, constitutes a human rights violation and finds its legal roots in different international human rights instruments, I will articulate how the denial of pain relief in childbirth could be defined as a form of GBV. To do so, however, we will have to go one step further: in fact, gender stereotypes must be considered as playing a paramount role[271] in women's reproductive lives, as I have discussed in the previous chapters. Starting from the assumption that, in the wording of the Istanbul Convention's article 3, '"gender" shall mean the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for women and men',[272] it immediately appears evident that the expectations, beliefs and traditional features attributed to pregnant and/or birthing women (and extensively described in chapter 1 of this thesis) can be linked to the notion of gender as articulated in the Istanbul Convention.

Such beliefs, prejudices and fixed gender roles attributed to men and women, especially in the reproductive sphere, might be detrimental to the full realisation of women's human rights in childbirth: in fact, within the regional Inter-American human rights system, the Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belém do Pará, 1994) states that 'stereotyping of women in the reproductive arena should be interpreted as violence against women';[273] in addition, the SR on Torture has highlighted how 'gender stereotypes play a role in downplaying the pain and suffering that certain practices inflict on women'.[274] This statement does not refer directly to childbirth: however, we can draw from it the conclusion that how stereotyping the reproductive role of women has repercussions not only in how birthing women are depicted, but also on how childbirth is handled medically. This allows us to link the stereotyping which leads to the mistreatment of childbirth pain with GBV, and to qualify the former

[271] See also CEDAW GR 35 (n 266) 6.
[272] Istanbul Convention (n 267).
[273] Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women- Convention of Belém do Pará. See also O'Connell and Zampas (n 257) 120.
[274] UN HRC (n 212) 4.

as one shape taken by the latter. Moreover, in the framework of the African system, the African Commission on Human and Peoples' Rights suggests that efforts to eliminate gender stereotyping 'be especially made to address patriarchal attitudes, as well as the prejudices of health care providers',[275] thereby stressing the connection between gender and attitudes of legislators and medical staff towards women and the pain they experience in the context of their reproductive life.

As for the term 'violence', the denial of pain relief during childbirth can definitely be defined as such. According to the UN 1993 Declaration on the Elimination of Violence Against Women, violence includes any act causing harm and/or suffering, implying that neglect and abandonment – including ignoring women's complaints and needs – is a violent act, whatever its motivation.

Thus, the denial of pain relief during childbirth is located at the edge between physical violence (an act – or a lack thereof – which causes physical suffering, possibly even amounting to inhumane and degrading treatment) and psychological/emotional violence (as 'Abuse/ humiliation: Non-sexual verbal abuse that is insulting, degrading, demeaning; (…) whether in public or private. It can be perpetrated by anyone in a position of power'[276]) within the realm of GBV.

### 3.2 Obstetric violence: a potentially effective legal device

If, as I have argued, the denial of pain relief during childbirth is placed within the larger framework of disrespect and abuse in maternal care, a relatively recent legal device can be operationalised in order for such abuses and human rights violations to be effectively identified and, from there, prosecuted or, better yet, prevented from happening in the first place: this is obstetric violence, defined for the first time within the domestic legal framework of Venezuela in 2007 as:

[275] African Commission on Human and Peoples' Rights, 'General Comment 2 on African Commission on Human and Peoples' Rights. General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a), and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' 15.

[276] UNHCR Optional Module on Gender-Based Violence (2005) 17 <www.unhcr.org/4371faad2.pdf UNHCR optional module GBV> accessed 14 June 2019.

> the appropriation of women's bodies and reproductive processes by health personnel, which is embodied in a dehumanizing treatment, in abuses of medicalization and pathologizing of natural processes, thus causing loss of autonomy and of free decision-making on a woman's own body and sexuality, negatively influencing women's quality of life.[277]

How can such a concept be useful for supporting the right to pain relief? To illustrate the grounds on which I defend such thesis, I will first consider, once again, childbirth as a social and cultural event embedded in gender. If, as Lynn Freedman and Kate Ramsey have remarked, 'Health systems are deeply embedded in society's broader social and political dynamics, which can contribute to disrespect and abuse of women giving birth',[278] then the assumption that common stereotyping on women hinders the full realisation of their human rights[279] applies to the health realm as well, and even more in the reproductive rights arena, in pregnancy and childbirth, which have traditionally been quintessentially female events.

Some of the most pervasive gender stereotypes on women – even more so in a moment where they are more vulnerable and 'prey' of their biology,[280] such as childbirth – are that, due to their emotional instability, they are incapable of making sensible decisions,[281] which on one hand leads to the potential violation of the right to informed consent, and to the loss of autonomy, and on the other 'requires' the presence, guidance and protection of someone who can take control of the situation, in this case healthcare providers – usually, a man. Clara O'Connell and Christina Zampas observed that women 'are thus perceived as individuals in need of being controlled and incapable of exercising their agency, and should therefore be denied access to health care services of their choice'.[282]

[277] Ley Orgánica Sobre el Derecho de las Mujeres a una Vida Libre de Violencia, Nº 38.668, lunes 23 de abril de 2007 art 15, comma 13. The original text reads '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' (my translation).

[278] Lynn P Freedman and Kate Ramsey, 'Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda' (2014) 92(12) Bulletin of the World Health Organization <www.scielosp.org/article/bwho/2014.v92n12/915-917/en/#> accessed 19 April 2019.

[279] O'Connell and Zampas (n 257) 117. See also Khosla and others (n 107) 134.

[280] See chapter 1 of this thesis.

[281] O'Connell and Zampas (n 257) 117.

[282] ibid.

Thus, authority, knowledge and hierarchy interplay with gender – and often, class and educational level[283] – and put birthing women in a disadvantaged position in which it becomes easier for their rights to be violated; the notion of obstetric violence articulates different types of such violations by rooting them in the power imbalance which results from (1) being a patient and (2) being a woman, pregnant or giving birth. This gives us leeway to advocate for a right to pain relief whose legal foundations might otherwise be difficult to trace in the context of pregnancy and childbirth: it is possible, I argue, to consider the denial of pain relief in childbirth as included in the practices defined as obstetric violence, which in turn is a type of GBV. Some of the practices considered as dehumanising and as constituting obstetric violence, as Juliana Tamayo Muñoz and others reported, 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.[284]

This way, practices which have long been normalised in health facilities – such as the absence of pain treatment, on the grounds that pain is regarded as a necessary component of childbirth – can be uncovered as human rights violations if only they are read through the prism of power and gender, even when women and medical staff themselves do not perceive them as such[285] due to their habits, traditions or beliefs. Alicia Yamin pointed out that:

> The dynamics of power at work in structuring health outcomes remain largely invisible if analysis focuses on the independent effects of individual risk factors, precluding fundamental challenges to the status quo. In a rights framework, a core public function of epidemiology is precisely to make the connections among (…) discrimination, inequality, and health visible, which requires contextual, multi-level analyses. Under this approach, misfortunes are understood as injustices - violations and are therefore, (…) actionable, rather than be ignored or accepted as inevitable.[286]

[283] Solnes Miltenburg and others (n 144) 7.

[284] Juliana Tamayo Muñoz and others, 'Obstetric Violence and Abortion. Contributions to the Debate in Colombia' (2015) <https://globaldoctorsforchoice.org/wp-content/uploads/Obstetric-Violence_and_Abortion_EN-final-1.pdf> 10 accessed 31 May 2019 (emphasis added).

[285] Freedman and Ramsey (n 278); Solnes Miltenburg and others (n 144).

[286] Alicia E Yamin, 'Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care' (2008) 10(1) Health and Human Rights 45, 48.

What a human rights approach to health and, more specifically, to childbirth adds to social medicine and social epidemiology is, Yamin argued, 'precisely to demand justifications and accountability, and there by to expose the hidden priorities and structures behind violations'.[287] If women are able to conceive themselves as subjects of rights, a 'rights framework provides a mechanism for reanalyzing and renaming "problems" as "violations," and, as such, something that need not and should not be tolerated'.[288]

In fact, what obstetric violence can help us to make visible are the patterns of 'abuse and negligence at the systemic level',[289], which go well beyond contingent medical practices. The neglect of women's needs and choices is part of a larger web of values and practices which permeate society at all levels. The fact that many women reports being mistreated, abandoned or even scolded and humiliated during childbirth reveals how, often, the mistreatment or total lack of treatment of pain is not a casual medical malpractice, but happens as a manifestation of deeper dynamics to be understood and properly contextualised if what we aim at is the elimination of un-dignified birthing practices. Analysing this mistreatment through the lens of obstetric violence as a form of GBV helps unpack the patterns and relations of power which would otherwise be harder to discern, and consequently act against.

Although the WHO has not (yet?) endorsed, as an organisation, the adoption of obstetric violence as a legal tool,[290] states such as Venezuela, Argentina and Porto Rico have introduced the term in their domestic legislation. By framing 'institutional violence as a manifestation of obstetric violence, the states include situations where state officials, personnel, or agents of public entities or institutions impede, obstruct, or delay women's access to public services or the enjoyment or their rights'.[291]

As Carlos Vacaflor pointed out, 'the legal concept of obstetric violence seeks to shed light on the ongoing lack of state oversight on the

[287] Yamin (n 286).
[288] ibid.
[289] Carlos H Vacaflor, 'Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina' (2016) 24(47) Reproductive Health Matters - Violence: a barrier to sexual and reproductive health and rights 65, 70.
[290] WHO, 'Prevention and elimination of disrespect and abuse during childbirth' (2014) <www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth-govnts-support/en/> accessed 12 June 2019.
[291] Vacaflor (n 289) 67.

provision of maternal health services in both the public and the private health sectors'.[292] Accordingly, the fact that states might become liable for such rights violations (through the creation of obstetric violence as a human rights violation) might push public authorities to act in the direction of better protecting, promoting and fulfilling women's rights in childbirth.

Obstetric violence is one of the tools we can utilise to trace a legal foundation for the absence of pain relief as a mistreatment of birthing women; as Joanna Erdman put it, 'the experience of abuse and disrespect with respect to any maternal care practice may be voiced across rights categories or through none at all, but an analytical method must be sufficiently open to capture its varied nature'.[293]

My argument is that the notion of obstetric violence, as recent and 'in progress' as it can be in the international human rights framework, could serve effectively as such an analytical method. It has to be kept in mind that the effectiveness of a human rights approach to women's reproductive life can be undermined if we only consider its abstract dimension, related to principles and general standards, without providing such approach with practical articulations and situations in which it may be used. To define what exactly constitutes obstetric violence is complex, but one possible approach could be, as hypothesised by Freedman and Ramsey, to:

> take local drivers of disrespect and abuse seriously, using both top-down and bottom-up approaches to incorporate normative standards into routine practice (…); simply promoting abstract standards through advocacy and education – or even through legal enforcement and punishment – is unlikely to solve the problem of disrespect and abuse. The abstract standards could only acquire meaning over time by careful attention to the lived experience of disrespect and abuse, and to the deeper dynamics of power that underlie it.[294]

Therefore, if a human rights-based approach is necessary, it may not be sufficient to set general standards and theories without them being based on the factual experience of women as patients; women's bodies, lived experiences and subjectivity should be taken into account in the

[292] Vacaflor (n 289) 66.
[293] Erdman (n 111) 4.
[294] Freedman and Ramsey (n 278).

implementation of existing human rights standards to pregnancy and childbirth, so as to be able to see it as structural and not contingent to particular contexts or circumstances.

Some authors, such as Fred Sai, went as far as to state that 'the focus of legal activism for women's rights should be less about the development of new laws and conventions, and rather more on education and creating a familiarity with and regular use of already existing instruments in the every-day situations of women's lives',[295] thereby stressing that what is needed may not necessarily be new human rights instruments, but rather, a different basis for the application of the existing ones – a basis which is gender-aware and which focuses on the actual practices and habits which constitute violations precisely because they are carried out on women in the context of childbirth.

Obstetric violence as a form of GBV, in fact, does not create new legal obligations: rather, it frames existing human rights by rooting the causes of their violations in specific settings and relations between genders, on one hand, and between medical staff and patient, on the other. Hence, women's rights come to be interpreted with an attention to gender and its implications in the realm of (reproductive) health, keeping in mind the consequences of the lack of such gender component; 'reproductive health is often compromised not because of lack of medical knowledge, but because of infringements of women's human rights. Powerlessness of women is a serious health hazard',[296] as rightfully pointed out by Cook. The legal notion of obstetric violence draws attention precisely to this powerlessness and creates a framework in which, among other mistreatments, the denial of pain relief could find a legal foundation.

If, as Yamin wrote, rights are:

> sites, as well as tools, of struggle, (…) then using rights to advance the health of impoverished and marginalized peoples around the world requires more than reference to positive norms; it also demands critiquing and expanding limited understandings of rights in theory and practice. Implicitly, doing so also requires challenging underlying premises about justice and power.[297]

[295] Fred Sai, *Adam & Eve and the Serpent* (International Planned Parenthood Federation 1994).

[296] Imogen Evans, 'Reproductive Health and Human Rights. Integrating Ethics, Medicine, and Law' (2004) 97(1) Journal of the Royal Society of Medicine 43, 44.

[297] Yamin (n 286) 46.

This is precisely what the concept of obstetric violence permits by focusing on 'challenging underlying premises about justice and power' regarding women's role and agency within determined environments and societies.

Obstetric violence as a legal device, in sum, allows us to take a sociological approach[298] to human rights in childbirth, meaning that 'rather than subsume individual experience under a human rights norm, it seeks to construct the content of that norm from the particulars of experience'.[299] By linking abstract norms (what Erdman defines as the 'principle-based approach'[300] to human rights) to the lived experience of birthing women within the (institutional) context in which births take place (allowing for the implementation of a 'sociological approach'[301]), one can perceive how, however varied and often contradictory, the experience of violations can help us find a material foundation to explain to what extent women's rights are (or are not) violated.

It should be noted, however, that gender-awareness is fundamental not only at a legal level, but also, and possibly even more so, at the societal level, including health facilities in which women give birth and citizens – especially women themselves. While creating a legal framework where the right to pain relief in childbirth finds its own space is necessary, limiting the scope of actions to it could be counterproductive,[302] in that it could end up punishing perpetrators who might even be unaware of the roots and causes of the human rights violations they are potentially responsible for. A two-sided approach is needed, involving law on one hand, and education of both medical staff and the general public on the other, to make patients and physicians conscious about how the meaning, values and beliefs attached to childbirth and how they interplay with gender; in addition, becoming aware that a dignified childbirth is one in which specific human rights are realised would benefit both birthing women and medical staff.

Given the absence of case law on pain relief in childbirth, obstetric violence as a legal device could be an effective way of pushing forward

[298] Erdman distinguishes the sociological approach from the principle-based human rights approach, the latter being theoretical and detached from the lived experience of right-bearers.
[299] Erdman (n 111).
[300] ibid.
[301] ibid.
[302] Rogelio Pérez D'Gregorio, 'Obstetric violence: a new legal term introduced in Venezuela' (2010) 111(3) International Journal of Gynaecology and Obstetrics 201.

a definition of dignified sexual and reproductive healthcare for women, including childbirth. This would also make room for the definition of pain relief in childbirth as a human right, as well as creating an opportunity for women to be aware of their rights and to demand accountability, and for medical staff to raise their own awareness and include the gender dimension in their everyday tasks, so that human rights violations are less likely to happen.

## 3.3 Conclusion

In this short section I have strived to demonstrate how the denial of pain relief in childbirth can, and ought to, be seen as a form of GBV on birthing women; the notion of GBV is also what allowed me to trace a connection between the argument for the existence of pain relief in childbirth as a human right, and the relatively recent legal concept of obstetric violence. The latter could set the foundation for a new stream of case law regarding not only human rights in childbirth in general (which is already happening, especially in Latin American countries), but also the very right to pain relief in childbirth. The latter is one aspect of a safe and dignified childbirth, in which, among other rights, both the right to health and the right to be free from cruel, inhumane and degrading treatment would be fully realised. The new legal paradigm should be accompanied by a shift in society, within and outside healthcare facilities, prompted by educational measures and raising awareness and attention on the issue.

# CONCLUSIONS

While pain relief in general is being increasingly acknowledged as a human right, and the discussion on patients' rights occupies an indisputable space within the human rights arena, pain in childbirth is remains largely ignored.

The lack of attention to this issue, be it on the part of medical staff, legislators, society, or even birthing women themselves, can be traced back to the persistence of deep-rooted stereotypes, beliefs and myths around the notion of woman, mother, and pain and its meaning. These dimensions all interact and enhance each other during childbirth and have traditionally caused women to be seen as stereotyped creatures who, ultimately, deserve the pain they are feeling as a consequence of their lust, or even sin. The meanings and values attached to childbirth pain make it difficult for it to be recognised as something which should be paid attention to and relieved. Consequently, while a universal human right to pain relief can arguably be derived from the right to health and to be free from cruel, inhumane and degrading treatment (ie prohibition of torture), a human right to pain relief in childbirth is more difficult both to formalise and to implement.

In this work, I analysed the reasons why this is so, the existing human rights framework on pain relief and the hurdles which have prevented a human right to pain relief in childbirth from being recognised. Accordingly, the notion of obstetric violence as a legal tool could be one way of operationalising women's rights in childbirth and, especially, their right to pain relief. Creating an international human rights instrument which recognises obstetric violence as a form of GBV could help include the different and unique situations related to the issue of pain relief in childbirth within a determined legal framework. In doing so, it would also reveal that the reasons that such human rights violations

are the result of issues that are structural, rooted in societal fabric and embedded in stereotypes and categorisations which create imbalanced gender-power relations. Viewing the denial of pain relief as (1) a form of dehumanised care in the specific context of women's reproductive life and (2) based on gender stereotypes, in fact, would allow for a definition of the violation of the right to pain relief in childbirth as a form of GBV. This would set the legal foundations for the existence and recognition of pain relief in childbirth as a fundamental human right.

The gender component must be considered if we are to recognise such a right: it is the way out of an ambiguous and problematic situation – both at the legal and at the social, political and medical level. The fact that it is women – and not men – who suffer from the denial of pain relief while giving birth, makes it a gender issue that cannot be left out if we aim at creating a theoretical framework first, and consequently a legal one, for human rights in childbirth.

To this day, there has been no case law whatsoever on the issue of pain in childbirth. This legal lacuna is due to mainly two factors: firstly, the lack of a positive right to pain relief in this situation – the legal complexity of which has been discussed in the previous chapter. Secondly, birthing women do not perceive themselves as entitled to that right, in that pain in childbirth is taken for granted as an essential component, not only by medical staff, but by women and by society more generally. Accordingly, a rights-bearer who does not *know* she is one, will not even attempt to have her rights recognised, let alone file a case for their violation.

Similarly, the lack of awareness and attention to the gendered implications of childbirth on the part of medical staff is often[303] what motivates the lack of attention to pain relief in childbirth. Therefore, while a gender-centred human rights approach is necessary to make pain relief a formal right and demand accountability for it, it is also of paramount importance to focus on education to prevent such rights violations from taking place. Indeed, sanctioning these mistreatments as human rights violations while neglecting the prevention aspect is not enough and might even be counterproductive: a double-sided approach has to be taken, and reproductive rights and gender studies education

[303] I am referring to an optimal situation with no financial/material constraints, ie in which medication and medical staff are readily available.

– both of medical staff and of citizens, especially women – have to be at the centre of governmental attention.

Education must involve both women (on their rights and on how to express their needs at such a crucial moment) and medical staff, thus leading to a paradigmatic shift that can allow for an institutional and legal one to follow. In fact, despite all the instruments and conventions available, Cook has stressed that 'women's rights are still considered "social" rather than "civil" or political, conditional on custom and religion rather than universal';[304] only by acting at the educational level can this *status quo* be reversed.

Through sensibilisation and education, on one hand, and specific, gender-aware legal devices, such as obstetric violence, on the other, we will be able to have pain relief in childbirth mainstreamed and recognised as a human right, and its denial[305] acknowledged as a human rights violation.

[304] Evans (n 296) 43.

[305] If and when such relief is requested, and when the denial of pain relief is not grounded on medical reasons.

# BIBLIOGRAPHY

## Books and articles

Allen RH and Singh R, 'Society and Family Planning Clinical Guidelines Pain Control in Abortion part 1 – Local Anesthesia and Minimal Sedation' (2018) 97 Contraception 471

Annas GJ, 'Human rights and health - the Universal Declaration of Human Rights at 50' (1998) 339(24) New English Journal of Medicine 1778

Beckett K, 'Choosing Cesarean. Feminism and the politics of childbirth in the United States' (2005) 6(3) Feminist Theory 251

Benatar D, 'Bioethics and Human rights. A Critical View' (2006) 32 Journal of Medical Ethics 17

Bergeron V, 'The Ethics of Cesarean Section on Maternal Request: a Feminist Critique of the American College of Obstetricians and Gynecologists' Position on Patient-Choice Surgery' (2007) 21(9) Bioethics 478

Boama V, 'Overcoming barriers to labor pain relief' (2011) 114 International Journal of Gynecology and Obstetrics Issue 207

Bordo S, 'Are Mothers Persons? Reproductive Rights and the Politics of Subjectivity' in *Unbearable Weight. Feminism, Western Culture, and the Body* (University of California Press 1984)

Brennan F, 'Palliative Care as an International Human Right' Special Article (2007) 33(5) Journal of Pain and Symptom Management 494

— Carr DB and Cousins M, 'Pain Management: A Fundamental Human Right' (2007) 105(1) International Anesthesia Research Society 205

Callister LC, 'Cultural influences on pain perception and behaviors' (2003) 15(3) Home Health Care Management and Practice 207

— 'Making meaning: Women's birth narratives' (2004) 33(4) Journal of Obstetrics, Gynecologic, and Neonatal Nursing 508

— 'Pain and Celebrating New Life: Women Giving Birth' in Lucas A, *Frontiers in Pain Research* (Nova Science Publisher Inc 2006) 157

Chigbu CO and Onyeka TC, 'Denial of pain relief during labor to parturients in southeast Nigeria' (2011) 114(3) International Journal of Gynecology and Obstetrics 226

Cohen E, 'The Animated Pain of the Body' (2000) 105(1) The American Historical Review 36
Conrad P, 'Medicalization and Social Control' (1992) 18 Annual Review of Sociology 209
Cook RJ, 'International Human Rights and Women's Reproductive Health' (1993) 24(2) Studies in Family Planning 73
Corretti C and Desai SP, 'The Legacy of Eve's Curse: Religion, Childbirth Pain, and the Rise of Anesthesia in Europe: c. 1200-1800s' (2018) 4 Journal of Anesthesia History 182
Cousins M, 'Relief of acute pain: a basic human right?' (2000) 172(3) Medical Journal of Anaesthesia 3
Daher M, 'Pain Relief is a Human Right'(2010) 11 Asian Pacific Journal of Cancer Prevention - MECC Supplement 97
Davis-Floyd R and others, 'The International MotherBaby Childbirth Initiative: A Human Rights Approach to Optimal Maternity Care' (2010) Midwifery Today 12-14, 64-66
Ditmore T, 'The Pains of Natural Childbirth: Eve's Legacy to Her Daughters' (2008) 16(2) Leaven Article 5
Doyle N, 'Writing the Body. The Work of the Body in Women's Childbearing Narratives' in *Maternal Bodies: Redefining Motherhood in Early America* (University of North Carolina Press 2018)
— 'Conclusion: In Search of the Maternal Body. Past and Present' in *Maternal Bodies: Redefining Motherhood in Early America* (University of North Carolina Press 2018)
Drapkin Lyerly A, 'Shame, Gender, Birth' (2006) 21(1) Hypatia 101
Evans I, 'Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law' (2004) 97(1) Journal of the Royal Society of Medicine 43
Fishman S, 'Recognizing Pain Management as a Human Right: A First Step' (2007) 105(1) Anaesthesia and Analgesia 8
Flagler E, Baylis F and Rodgers S, 'Bioethics for clinicians: 12. Ethical dilemmas that arise in the care of pregnant women: rethinking "maternal–fetal conflicts"' (1997) 156(12) Canadian Medical Association Journal 1729
Gispen MEC, 'Poor Access to Pain Treatment: Advancing a Human Right to Pain Relief, Report to the International Federation of Health and Human Rights Organizations' Report to the International Federation of Health and Human Rights Organisations (IFHHRO) (2012) 16
Hanson C, *A Cultural History of Pregnancy. Pregnancy, Medicine and Culture, 1750–2000* (Palgrave MacMillan 2004)
Hern WM, 'Is Pregnancy Really Normal?' (1971) 3(1) Family Planning Perspectives 5
Herring J and Wall J, 'The nature and significance of the right to bodily integrity' (2017) 76(3) The Cambridge Law Journal 566
Hogerzeil H and others, 'Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts?' (2006) 368 Lancet 305
Hutson CR, '"Saved through Childbearing": The Jewish Context of 1 Timothy 2:15' (2014) 56(4) Novum Testamentum 392

Imani F and Safari S, 'Pain Relief is an Essential Human Right. We Should be Concerned about it' (2011) 1(2) Anesthesiology and Pain Medicine 55
James S and Palmer S, *Visible Women. Essays on Feminist Legal Theory and Political Philosophy* (Hart Publishing 2002)
Jarvis Thomson J, 'A Defense of Abortion' (1971) 1(1) Philosophy & Public Affairs 47
Johnson C, 'The Political "Nature" of Pregnancy and Childbirth' (2008) 41(4) Canadian Journal of Political Science / Revue canadienne de science politique 889
Jukic M and Puljak L, 'Legal and Ethical Aspects of Pain Management' (2018) 47(1) Acta Medica Academica 18
Katz Rothman B, 'The Social Construction of Birth' (1977) 22(2) Journal of Midwifery and Women's Health 9
Kelley J, Evans MDR and Headey B, 'Moral Reasoning and Political Conflict: The Abortion Controversy' (1993) 44(4) The British Journal of Sociology 589
Khosla R and others, 'International Human Rights and the Mistreatment of Women During Childbirth' (2016) 18(2) Health and Human Rights Journal 131
Klassen PE, 'Sacred Maternities and Postbiomedical Bodies: Religion and Nature in Contemporary Home Birth' (2001) 26(3) Signs 775
Kristeva J and Goldhammer A, 'Stabat Mater' (1985) 6(1/2) Poetics Today, The Female Body in Western Culture: Semiotic Perspectives 133
Lazarus ES, 'What Do Women Want? Issues of Choice, Control, and Class in Pregnancy and Childbirth' (1994) 8(1) Medical Anthropology Quarterly, New Series 25
Leifer M, 'Pregnancy' (1980) 5(4) Signs, Women: Sex and Sexuality 754
Lipman AG, 'Pain as a human right: the 2004 Global Day Against Pain' (2005) 19(3) Journal of Pain and Palliative Care Pharmacotherapy 85
Lisboa LV, Ataíde Lisboa JA and Nunes Sá K, 'Pain relief as a way to legitimate human rights' (2016) 17(1) Revista da Dor 57
Little MO, 'Why a Feminist Approach to Bioethics?' (1996) 6(1) Kennedy Institute of Ethics Journal 1
Lowe NK, 'The nature of labor pain' (2002) 186(5) The American Journal of Gynecology and Obstetrics 16
Macpherson C and Aarons D, 'Overcoming barriers to pain relief in the Caribbean' (2009) 9(3) Dev World Bioeth 99
Madden KL and others, 'Pain relief for childbirth: The preferences of pregnant women, midwives and obstetricians' (2013) 26 Women and Birth 33
Malacrida C and Boulton T, 'Women's Perception of Childbirth Choices: Competing Discourses of Motherhood, Sexuality, and Selflessness' (2012) 26(5) *Gender and Society* 748
— 'The best laid plans? Women's choices, expectations and experiences in childbirth' (2014) 18(1) Health 41
Martin KA, 'Giving Birth Like a Girl' (2003) 17(1) *Gender and Society* 54

McCauley M and others, '"We know it's labour pain, so we don't do anything": healthcare provider's knowledge and attitudes regarding the provision of pain relief during labour and after childbirth' (2018) 18(444) BMC Pregnancy and Childbirth 5

Nastaran Beigi M Ai and others, 'Women's experience of pain during childbirth' (2010) 15(2) Iran J Nurs and Midwifery Res 77

Novick T, 'Pain and Production in Eden: Some Philological Reflections on Genesis III 16' (2008) 58(2) Vetus Testamentum 235

Norr K and others, 'Explaining Pain and Enjoyment in Childbirth' (1977) 18(3) *Journal of Health and Social Behavior* 260

Oakley A, 'A Case of Maternity: Paradigms of Women as Maternity Cases' (1979) 4(4) Signs, The Labor of Women: Work and Family 607

O'Connell C and Zampas C, 'The human rights impact of gender stereotyping in the context of reproductive health care' (2018) (144) International Journal of Gynecology and Obstetrics 116

Pérez D'Gregorio R, 'Obstetric violence: a new legal term introduced in Venezuela' (2010) 111(3) International Journal of Gynaecology and Obstetrics 201

Pine RN, 'Benten v Kessler: The RU 486 import case' (1992) 20 Law, Medicine and Health Care 238

Prosen M and Tavčar Krajnic M, 'Sociological Conceptualization of the Medicalization of Pregnancy and Childbirth: The Implications in Slovenia' (2013) 43(3) Revija Za Sociologiju 251

Purdy L, 'Medicalization, Medical Necessity and Feminist Medicine' (2001) 15(3) Bioethics 249

Rich A, *Of Woman Born. Motherhood as experience and institution* (WW Norton & Company 1995)

Rogers DD, 'Rockabye Lady: Pregnancy as Punishment in Popular Culture' (1992) 26(1) Journal of American Studies 81

Rosengren WR, 'Social Sources of Pregnancy as Illness or Normality' (1961) 39(3) Social Forces 260

— 'The Sick Role During Pregnancy: A Note on Research in Progress' (1962) 3(3) Journal of Health and Human Behavior 213

— 'Social Status, Attitudes toward Pregnancy and Child-Rearing Attitudes' (1962) 41(2) Social Forces 127

Sai F, *Adam & Eve and the Serpent* (International Planned Parenthood Federation 1994)

Sell SE and others, 'Looks and knowledge: experiences of mothers and nursing staff regarding post-caesarean section pain' (2012) 21(4) Text Context Nursing, Florianópolis 766

Shakibazadeh E and others, 'Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis' (2018) 125(8) BJOG 932

Shanley ML, '"Surrogate Mothering" and Women's Freedom: A Critique of Contracts for Human Reproduction' (1993) 18(3) Signs 618

Skowronski GA, 'Pain relief in childbirth: changing historical and feminist perspectives' (2015) (43) (History Supplement) Anaesthesia and Intensive Care 27

Solnes Miltenburg A and others, 'Maternity care and Human Rights: what do women think?' (2016) 16(1) BMC international health and human rights
Sreeparna C, Arima M and Suraj J, '"Safe", yet violent? Women's experiences with obstetric violence during hospital births in rural Northeast India" (2017) 120(7) Culture, Health & Sexuality 815
Steel A and others, 'Managing the pain of labour: factors associated with the use of labour pain management for pregnant Australian women' (2015) 18 Health Expectations 1634
Vacaflor CH, 'Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina' (2016) 24(47) Reproductive Health Matters - Violence: a barrier to sexual and reproductive health and rights 65
Van Es A, 'Prevention of Torture and Cruel or Inhuman and Degrading Treatment in Healthcare' in Klotz S and others, *Healthcare as a Human Rights Issue. Normative Profile, Conflicts and Implementation* (Transcript Verlag 2017)
Walzer Leavitt J, 'Birthing and Anesthesia: The Debate over Twilight Sleep' (1980) 6(1) Signs, Women: Sex and Sexuality, Part 2 147
Wang X and Wang F, 'Labor pain relief for parturients: We can do better' (2014) 8(1) Saudi Journal of Anesthesia 1
Yamin AE, 'Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care' (2008) 10(1) Health and Human Rights 45
Young A, 'The Anthropologies of Illness and Sickness' (1982) 11 Annual Review of Anthropology 257
Ziegler M, 'Some Form of Punishment: Penalizing Women for Abortion' (2018) 26(3) William & Mary Bills of Rights Journal, Art. 6 735

## Official documents

African Commission on Human and Peoples' Rights, 'General Comment 2 on African Commission on Human and Peoples' Rights. General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a), and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2014)
Charter of Fundamental Rights of the European Union, European Union (2000), 2000/C 364/01
Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Council of Europe (1997) ETS164
Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention), Council of Europe (2011) ETS210
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Council of Europe (1987) ETS5
Inter-American Convention to Prevent and Punish Torture, Organization of American States, OEA 67 (1985)

Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belém do Pará) (1994)
Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia de Venezuela (2007) Nº 38.668, lunes 23 de abril de 2007
Office of the High Commissioner for Human Rights, 'Submission from the Global Respectful Maternity Care Council, On the Implementation of the Technical Guidance on the Application of a Human Rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality' (2012) A/HRC/21/22
Office of the High Commissioner for Human Rights, 'Factsheet No. 4 (Rev.1), Combating Torture' (2002)
Office of the United Nations High Commissioner for Human Rights and World Health Organization, 'The Right to Health. Factsheet No 31' (2008)
Office of the High Commissioner for Human Rights, 'Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights' (2010)
Organization of African Unity (OAU), African [Banjul] Charter on Human and Peoples' Rights (1987) CAB/LEG/67/3 rev. 5, 21, I.L.M. 58
Report of the Special Rapporteur on the question of torture, Manfred Nowak, Civil and Political Rights, Including The Questions of Torture And Detention Torture and other cruel, inhuman or degrading treatment, UN Commission on Human Rights (2006) E/CN.4/2006/6
United Nations Committee for the Elimination of All Forms of Discrimination Against Women, 'General Recommendation No 19: Violence Against Women' (1992)
— 'General Recommendation No 24 on art 12 of the Convention' (1999)
— 'General Recommendation No 35 on gender-based violence against women, updating General Recommendation No 19' (2017)
United Nations General Assembly, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984, entered into force 26 June 1987) A/RES/39/46
United Nations General Assembly, Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly (2007) A/RES/61/106
United Nations General Assembly, Convention on the Rights of the Child (1989) 1577 UNTS 3
United Nations General Assembly, International Convention on the Elimination of All Forms of Racial Discrimination (1965) 669 UNTS 195
United Nations General Assembly, International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990) A/RES/45/158
United Nations General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women (1979) 1249 UNTS 13
United Nations General Assembly, Declaration on the Elimination of Violence against Women (1993) A/RES/48/104

United Nations High Commissioner for Human Rights, 'Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality' (2012) A/HRC/21/22

United Nations High Commissioner for Refugees, Optional Module on Gender-Based Violence (2005) <www.unhcr.org/4371faad2.pdf UNHCR optional module GBV> accessed 14 June 2019

United Nations Human Rights Council, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak' (2008) A/HRC/7/3

— 'Resolution 11/8, Preventable maternal mortality and morbidity and human rights' (2009) A/RES/11/8

—Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak' (2009) A/HRC/10/44

— 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Méndez' (2013) A/HRC22/53

— 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Méndez' (2016) A/HRC/31/57

International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171

International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3

United Nations, Statement by the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, on the occasion of the inauguration of the NGO Committee for Rare Diseases at the United Nations Geneva, 11 November 2016

United Nations Committee on Economic, Social and Cultural Rights, 'General Comment No. 14: The Right To The Highest Attainable Standard Of Health' (2000) ) E/C.12/2000/4.

United Nations Educational, Scientific and Cultural Organization, Universal Declaration on Bioethics and Human Rights (2006)

United Nations Entity for Gender Equality and the Empowerment of Women, Beijing Declaration and Platform for Action. The Fourth World Conference on Women (1995)

United Nations Voluntary Fund for Victims of Torture, 'Interpretation of Torture in the light of the Practice and Jurisprudence of International Bodies' (2011) <www.ohchr.org/Documents/Issues/Torture/UNVFVT/Interpretation_torture_2011_EN.pdf> accessed 06 July 2019

Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III)

World Health Organization Constitution (1947) A/RES/131

World Health Organization Europe, Declaration on the Promotion of Patients' Rights in Europe (1994) ICP/HLE 121

World Health Organization, 'Prevention and elimination of disrespect and abuse during childbirth' (2014) <www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth-govnts-support/en/> accessed 12 June 2019
— 'WHO Statement on the prevention and elimination of disrespect and abuse during facility-based childbirth' (2014) <https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf;jsessionid=4DF6D01F6C0302AE3EA7405A6E489B19?sequence=1> accessed 12 June 2019
— 'WHO Standards for Improving Quality of Maternal and Newborn Care in Health Facilities' (2016) <www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en> accessed 12 June 2019
— 'WHO Recommendations: Intrapartum care for a positive childbirth experience' (2018) <www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/> accessed 12/06/2019
World Medical Organization Declaration on Disaster Preparedness and Medical Response (Montevideo 2011)

## Case law

European Court of Human Rights
*AK v Latvia* App no 33011/08
*Tysiąc v Poland* App no 5410/03, ECHR 2007-I

## Internet sources

Active Citizenship Network, European Charter of Patients' Rights (2002) <http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co108_en.pdf> accessed 12 April 2019
Amnesty International USA,' Deadly Delivery. The maternal health care crisis in the United States of America' (2011) <www.amnestyusa.org/files/deadlydeliveryoneyear.pdf> accessed 15 May 2019
Asociación El Parto es Nuestro, 'Resumen de jurisprudencia del Tribunal Europeo de Derechos Humanos sobre Violencia Obstétrica' (2016) <www.elpartoesnuestro.es/sites/default/files/recursos/documents/jurisprudencia_castellano.pdf> accessed 06 June 2019
Centre for Reproductive Rights, 'Briefing paper. Reproductive rights violations as torture and cruel, inhuman, or degrading treatment or punishment: a critical human rights analysis' (2010) <https://reproductiverights.org/sites/crr.civicactions.net/files/documents/TCIDT.pdf> accessed 06 July 2019
D'Ambruoso L, Abbey M and Hussein J, 'Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana' (2005) 5(140) BMC Public Health <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-5-140> accessed 31 May 2019

Diamandouros NP, 'Patients' rights in Europe today', Speech by the European Ombudsman, to the Second Hygeia- Harvard Medical International Conference – 'Preventive Medicine in the 21st Century', Athens, Greece, 3 June 2005 <www.ombudsman.europa.eu/it/speech/en/334> accessed 25/03/2019

Erdman JN, 'Commentary: Bioethics, Human Rights, and Childbirth' (2015) 17(1) Health and Human Rights <www.hhrjournal.org/2015/06/commentary-bioethics-human-rights-and-childbirth/> accessed 27 March 2019

European Court of Human Rights, 'Factsheet. Reproductive Rights' (2019) <www.echr.coe.int/Documents/FS_Reproductive_ENG.pdf> accessed 28 May 2019

Freedman LP and Ramsey K, 'Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda' (2014) 92(12) Bulletin of the World Health Organization <www.scielosp.org/article/bwho/2014.v92n12/915-917/en/#> accessed 19 April 2019

International Association for the Study of Pain, 'Global Day Against Pain 2004, Geneva' <www.iasp-pain.org/GlobalYear/RighttoPainRelief> accessed 12 April 2019

— Declaration of Montréal. Declaration that Access to Pain Management Is a Fundamental Human Right (2010) <www.apsoc.org.au/PDF/Publications/DeclarationOfMontreal_IASP.pdf > accessed 28 March 2019

International Conference on Primary Health Care, Declaration of Alma Ata, International Conference on Primary Care <www.who.int/publications/almaata_declaration_en.pdf> accessed 28 March 2019

Lohman D, Schleifer R and Amon JJ, 'Access to pain treatment as a human right' (2010) 8(8) BMC Medicine 1 <www.biomedcentral.com/1741-7015/8/8> accessed 25 March 2019

Long D, *Guide to Jurisprudence of Torture and Ill-Treatment. Article 3 of the European Convention for the Protection of Human Rights* (Association for the Prevention of Torture, Geneva 2002) <www.apt.ch/content/files_res/Article3_en.pdf> accessed 05 July 2019

Marrero L and Brüggemann OM, 'Institutional violence during the parturition process in Brazil: integrative review' (2018) 71(3) Revista Brasileira de Enfermaria <www.scielo.br/scielo.php?pid=S0034-71672018000301152&script=sci_arttext> accessed 15 April 2019

Norris S, 'When gynecologists gaslight women' (*Newsmavens*, 2018) <https://newsmavens.com/special-review/914/when-gynecologists-gaslight-women> accessed 31 May 2019

Osservatorio sulla Violenza Ostetrica Italia (OVOItalia), 'Violenza ostetrica in Italia: ora abbiamo i dati autorevoli' (2017) <https://ovoitalia.wordpress.com/2017/09/21/violenza-ostetrica-in-italia-ora-abbiamo-i-dati-autorevoli/> accessed 31 May 2019

Perera D, '"When helpers hurt": women's and midwives' stories of obstetric violence in state health institutions, Colombo district, Sri Lanka' (2018) 18(211) BMC Pregnancy and Childbirth <https://link.springer.com/content/pdf/10.1186%2Fs12884-018-1869-z.pdf> accessed 31 May 2019

Tamayo Muñoz J and others, 'Obstetric Violence and Abortion. Contributions to the Debate in Colombia' (2015) <https://globaldoctorsforchoice.org/wp-content/uploads/Obstetric-Violence_and_Abortion_EN-final-1.pdf> accessed 31 March 2019

The International Childbirth Initiative, '12 Steps to Safe and Respectful Mother Baby-Family Maternity Care' (2018) <http://intlcb.wpengine.com/wp-content/uploads/2019/12/ICI_12Steps_ENGLISHfull.pdf> accessed 20 April 2019

United Nations, 'Gender Equality' (2019) <www.un.org/en/sections/issues-depth/gender-equality/> accessed 25 June 2019

Vargas Rojas V, '"Dijo que si nos gustó abrirnos aguantáramos ahora": Mujeres narran la violencia obstétrica en primera persona' (*El Desconcierto*, 31 August 2018) <www.eldesconcierto.cl/2018/01/30/dijo-que-si-nos-gusto-abrirnos-aguantaramos-ahora-mujeres-narran-la-violencia-obstetrica-en-primera-persona/> accessed 31 May 2019

Vivilaki V and Antoniou E, 'Pain relief and retaining control during childbirth. a sacrifice of the feminine identity?' (2009) 3(1) Health Science Journal <www.hsj.gr/medicine/pain-relief-and-retaining-control-during-childbirth-a-sacrifice-of-the-feminine-identity.php?aid=3647> accessed 25 March 2019

White Ribbon Alliance, 'Respectful Maternity Care. The Universal Rights of Childbearing Women' (2011) <www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf> accessed 20 April 2019

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