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The diagnosis: a conceptualisation of VAWH

Unravelling the notion of violence against women's health

The *anamnesis* leads us now to the diagnosis. In this chapter I will unravel the innovative notion of VAWH as conceived in this book, which will pave the way for the analysis of states' obligations in chapter 3 (the 'treatment'). Going back to the philosophical metaphor that I used as *fil rouge* of this book, Greek physicians undertook detailed histories and examinations of patients, noting all elements that were useful for the diagnosis, including the course of the disease over time.[1] In my book, these elements have been the judgments of human rights courts and national courts, and the views of UN treaty bodies, related to specific aspects of the relationship between VAW on one hand, and the rights to health and to reproductive health on the other. It should be said that my analysis might seem limited – I looked into around seventy decisions. A database is not the purpose of this book, which aims to reflect on a precise relationship and analyse it using a medical metaphor to achieve a reconceptualisation of states' obligations in the field. It is true, indeed, that Hippocratic medicine was also founded on the available – hence, surely not 100 per cent complete – evidence-based knowledge.[2] As interestingly argued by one author, who relied on the rhetorical theory, 'all theoretical discussions of international law are incomplete in one way or the other,' and the reason is that theorists 'choose,' they emphasise different aspects of the discipline.[3]

To paraphrase the most common definition of VAW – violence against women is a violation of women's human rights – violence against *women's health* constitutes a violation of *women's right to health* and *right to reproductive health*. From the analysis in chapter 1, the notion of VAWH can encapsulate both a vertical and a horizontal dimension of violence, namely the interpersonal dimension between individuals and an institutional one, which is characterised by laws and policies in the field of health. VAW always violates a woman's rights to health and to reproductive health. At the same time, state policies and laws in the field of health, such as the criminalisation of abortion (as showed in chapter 1), might themselves cause, or contribute to cause, violence. From the *anamnesis*, however, I draw the lesson that it is essential to consider as state policies and laws in the field of health

the practice of private parties, such as health personnel and hospitals, exercising public functions. Sonya Charles first linked DV and forced medical treatment – respectively belonging to the horizontal and vertical dimensions of my analysis – and examined them both as forms of VAW.[4] Her argument anticipated mine. Nonetheless, from a legal point of view, although both are examples of VAW, in the case of DV the state is responsible for not preventing and/or suppressing VAW committed by private parties, whereas the state is responsible in cases of forced medical treatment because of its laws, or as a consequence of the action of its organs (for example the courts that authorise coercive practices), or because of the action of the health personnel, who are performing a public function in the field of health. In terms of state obligations, this difference matters.

One might wonder why the definition of VAW is not sufficient to encompass both the dimensions as I conceive them in this book. If we look at General Recommendation No. 35, adopted in 2017, it is clear that the CEDAW Committee conceived all forms of violence as potentially falling within the definition of VAW, including the criminalisation of abortion, for example. The Committee also argued that an international custom on the prohibition of VAW had consolidated. Nonetheless, I contended in the introduction that this latter affirmation – pivotal and progressive it might be – only partly corresponds to state practice.[5] VAW is usually conceived as interpersonal violence, in which the actors might also be organs of the state, and less as a system of health policies and laws which cause VAW.[6] However, if we look at VAW from the perspective of the right to health, then it is possible to argue that the macro-concept of VAWH can encapsulate both dimensions of violence. Like that of VAW, the concept of VAWH is not a term in criminal law, but rather an 'umbrella' definition that grasps the two dimensions of violence, each characterised by specific, gender-based crimes or practices. I will argue in these pages that, compared to the idea of VAW, this new concept can be enriched by another element, the limitation of women's autonomy, which will be construed in these pages along human rights-based lines.

In the introduction, I 'de-constructed' the idea of VAW, analysing it from five different perspectives; in this chapter I will 'construct' the concept of VAWH, in an attempt to provide the clearest conceptualisation of my argument. Being a framework definition, VAWH does not include the element of intent. Nonetheless, I will argue in favour of the identification of a pattern of conduct in relation to VAWH, which will be relevant for re-conceptualising states' obligations. I will conclude the chapter by reflecting on the public/private divide and how it might be challenged by the concept of VAWH.

What is violence against women's health?

The definition of VAW included in the Council of Europe Istanbul Convention, which reflects legal developments on this issue at the international level, constitutes an excellent starting point for the analysis. VAW means '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' (Article 3(a), Istanbul Convention). The concept of VAWH can also encompass all acts that cause or are likely to cause harm to women. This book theorises that these acts can be either 'horizontal' or 'vertical' forms of violence. Like VAW, VAWH makes no reference to the gender or the nature of the perpetrator. It emerged from chapter 1 that the perpetrator is not necessarily a male actor. For example, it is common practice that FGM/C are performed by women belonging to the community of the girl who undergoes it. Obstetricians might be women. In my book, the state can also be a perpetrator, not just through its agents, but also through laws and policies in the field of health that cause, or create the conditions for, VAWH.

In this paragraph, I will specifically reflect on the term 'harm,' although my purpose is not to investigate all the theories that legal scholars have elaborated over the centuries on this legal concept. Harm is usually related to criminal law, but in this book I see VAWH as an 'umbrella' concept, rather than a distinct crime, which is more comprehensive and better describes the two dimensions of violence as I theorised them in chapter 1. In this section I will not consider harm in relation to specific crimes which fall under the concept of VAWH, either.

Let us start from an apparently easy question: what is harm? In 1859 John Stuart Mill elaborated the following principle:

> The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant.[7]

In a very simple, and admittedly not exhaustive, description, harm consists in a violation of legally protected interests. In his famous work of 1984, the legal philosopher Joel Feinberg conceived harm as a 'wrongful setback to interests,'[8] which is an interesting definition even though a 'set-back to interests is not considered as harmful if it has been voluntarily consented to.'[9]

What protected interest is violated in cases of VAWH? When considering rape, it was argued that the harm 'lies in the violation of sexual autonomy and bodily integrity,' with the consequence that the protected interest can be precisely identified in sexual autonomy.[10] To turn to VAWH, I consider that the protected interests capable of embracing the two dimensions of violence are a woman's rights to health and to reproductive health, which include, but are not limited to, sexual and reproductive autonomy. Hence, harm consists (or, better, harms consist) in violation of those rights to health and to reproductive health. As has been argued, 'different harms may ensue from the same violations and one of the determining factors may be the gender of the victim.'[11]

The second, related, question concerns whether or not it is possible to 'measure' harm in international human rights law. In the *Valiulienė v. Lithuania* case

decided at European level, for example, Loreta Valiulienė suffered DV at the hands of her former partner. Her physical injuries were minor, but she was repeatedly, and violently, verbally abused. Was the violation of her human right – in this case, freedom from torture, inhuman or degrading treatment – less severe because she was not permanently, physically injured? Psychological harm might be disregarded, and often has been, and considered 'less important' than physical harm. Quite to the contrary, psychological harm has long-lasting consequences. The ECtHR argued, in *Valiulienė*, that it could not 'turn a blind eye to the psychological aspect of the alleged ill-treatment … psychological impact is an important aspect of domestic violence,'[12] and it found that Lithuania had violated Article 3 ECHR. It can be argued that, according to this jurisprudence, there is no pre-determined 'threshold' below which an act of gender-based violence is considered as not violence. Confirming this point, in several cases of DV the ECtHR has applied Article 3 prohibiting torture, inhuman or degrading treatment, without proceeding to analyse the level of severity. In her dissenting opinion on *Valiulienė*, Judge Jõcienė contended that the applicant's right to respect for private and family life had been violated, and *not* her right to be free from torture, inhuman or degrading treatment or punishment, because Article 3 ECHR requires a certain level of intensity to be triggered.[13] The position of the judge deserves some attention, and it is not devoid of legal arguments, but on one hand it raises doubts about how far severity should be considered in cases of DV, which risks minimising psychological harm, and on the other hand reference to the victim/survivor's right to privacy might be counter-productive, since it might bring the analysis back to the public/private divide that has been fought over by feminists for decades.

In her work on reproductive freedom and torture, Ronli Sifris considered that 'there is clearly no bright line dividing pain that is sufficiently intense to be categorised as severe, and pain that falls below this threshold.'[14] She then turned to restrictions on abortion, and argued that 'legally coercing a woman to carry an unwanted pregnancy to term is not only an abuse of her basic human rights, but may also be extremely damaging from a mental health perspective.'[15] The use of the adverb 'legally' is interesting for my purposes, because it identifies the perpetrator as the state, through its laws and policies. Restrictions on abortion might also have physical effects, especially when a woman decides to undergo 'unsafe abortions,' an expression which includes procedures carried out below the minimum medical standards and performed by individuals without the necessary skills.[16]

VAWH not only causes harm, manifesting as bodily injury, fear, anguish and psychological pressure, but also leads to the adoption of behaviours that limit women's autonomy, causing further harm. Consider, for example, that many women who have been raped adjust their behaviour because they fear being raped again – they might never leave their house alone, or at night – and suffer a new form of harm.[17] It is a double harm: the harm of rape, and the harm caused by the psychological consequences of rape. The same can be said for DV, when

a woman, fearing abuse, decides to stay at home or to avoid contact with friends or relatives. Fear of being subjected to traditional practices such as FGM/C may prevent a woman from going back to her country of origin. The kind of harm that is discussed in these pages is fundamental where OV has occurred. As I saw in chapter 1, cases of obstetric violence tend to be brought to court only when they lead to permanent physical injuries to a woman and, as a consequence, to a complaint of malpractice or of negligent behaviour by a practitioner. Nonetheless, this is only a limited view of the problem, because in the majority of cases, I venture to say, OV causes psychological and possibly long-lasting harm(s).

Finally, harm must be considered in the social context of the unequal power relations of women and men. Harm is 'gendered'. Harm may be caused to women because they are women, or may affect women disproportionately, so is inflicted on women *as a group*. Needless to say, this does not mean that harm must be conceived as collective and not as individual. Such a position would echo some national laws that considered rape as a crime against 'morality,' against the male actor exercising his control over the woman.[18] Instead, it means that an act of violence that a woman endures is not just an individual act, but also the product of an 'institution,' which 'reinforces the group-based subordination of women to men.'[19] Ruth Rubio-Marín has contended in that respect that 'looking at the harms produced by violations allows for an understanding of rights violations … as a distortion of relationships and network systems that are sustained by these rights in a way that is especially relevant for women.'[20]

VAWH as a form of discrimination against women: patterns of discrimination

VAWH is a form of discrimination against women *because* they are women and/or that affects women disproportionately, and it is structural, meaning that this form of violence is rooted in society, and based, as explained by the Council of Europe Istanbul Convention, on the 'crucial social mechanisms by which women are forced into a subordinate position compared with men.'[21] It is structural subordination, which is clarified by the control of sexuality exercised over girls through FGM/C, but also in the subjugation of women in rape and domestic violence. In the vertical dimension, the element of structural subordination is shown in the attitude towards women in the medical sector, where doctors decide on behalf of women, or after obtaining a 'coerced', not entirely informed or free, consent – and laws and policies allow them to do so. Even though juridical equality has been gradually accepted by states, and forms of subjugation of women have been legally removed, 'lifting legal impediments [i]s not sufficient to dislodge the deeply ingrained patterns of prejudice and disadvantage suffered by women.'[22] Substantive equality is far from being achieved.

From a legal point of view, the structural aspect of VAWH can be seen in 'patterns of discrimination', which will be useful when we come to reconceptualise states' obligations in chapter 3. A 'pattern of discrimination' means not just social and cultural patterns that are rooted in society, but also the persistence of and the

'tolerance' states demonstrate towards VAW, and in particular to VAWH, as it is conceived here. The 'societal' pattern of discrimination and the 'state' pattern of discrimination are, needless to say, interconnected and mutually reinforcing. This distinction is pivotal in terms of states' obligations: the state has legal obligations to prevent VAWH by changing cultural patterns that consider the woman as subordinated to the man,[23] but it also, as I will discuss in chapter 3, has obligations to disrupt the 'pattern of discrimination' represented by laws and policies in the health field that, directly or indirectly, perpetuate the stereotyped gender roles of women and men in society, and thereby cause violence. The ESCR Committee, in its GC No. 20, clearly defined systemic discrimination in this key passage:

> The Committee has regularly found that discrimination against some groups is pervasive and persistent and deeply entrenched in social behaviour and organization, often involving unchallenged or indirect discrimination. Such systemic discrimination can be understood as legal rules, policies, practices or predominant cultural attitudes in either the public or private sector which create relative disadvantages for some groups, and privileges for other groups.[24]

Let us focus first on the horizontal dimension. Both the Inter-American and the European mechanisms for protecting human rights have referred to 'patterns' of discrimination in judgments concerning DV. For instance, in *Maria da Penha v. Brazil*, the IACommHR held that:

> tolerance by the State organs is not limited to this case; rather, it is a pattern. The condoning of this situation by the entire system only serves to perpetuate the psychological, social, and historical roots and factors that sustain and encourage violence against women … the violence … is part of a general pattern of negligence and lack of effective action by the State in prosecuting and convicting aggressors … general and discriminatory judicial ineffectiveness also creates a climate that is conducive to domestic violence.[25]

In *Lenahan (Gonzáles) v. United States*, the IACommHR found '[t]he systemic failure of the United States to offer a coordinated and effective response to protect Jessica Lenahan and her daughters from domestic violence [which] constituted an act of discrimination … and a violation of their right to equality before the law.'[26] A 'more general context of gender violence and impunity' was emphasised in the report of the IACommHR in *López Soto v. Venezuela*, [27] and reinforced by the IACHR, which stressed how the 'judicial inefficiency' provoked an 'environment of impunity,' which in turn facilitated the repetition of acts of violence.[28] The IACommHR described sexual violence as a 'multi-dimensional problem,' the product of a 'social environment in which violence is tolerated.'[29]

Turning to the European human rights law system, in *Opuz v. Turkey* the ECtHR found Turkey responsible for violating Article 14 ECHR (prohibition of discrimination) because, although it had adopted a law to counter DV, discrimination resulted 'from the general attitude of the local authorities, such as the manner in which the women were treated at police stations when they reported domestic violence and judicial passivity in providing effective protection to

victims.'[30] Despite the number of DV cases reported in the area where Nahide Opuz lived, the police did not investigate her complaints of DV and the courts easily dismissed them, reproducing the public/private divide which international human rights law had begun to disrupt starting from the 1990s. The ECtHR also emphasised how the 'general discriminatory judicial passivity … created a climate that was conducive to domestic violence.'[31] This outcome is confirmed in another judgment, *Talpis v. Italy*, where the Court found that Italian authorities had 'condoned' the violent acts against Elisaveta Talpis – whose son was killed by her husband – and that she had been a victim of discrimination. The Court also referred to the 'socio-cultural attitude of tolerance of DV.'[32] Quite interestingly, and surprisingly to a certain extent, the Court departed from a previous judgment also involving Italy, filed by Giulia Rumor,[33] explicitly saying that the circumstances were different, because in *Rumor* the legislative framework existing in Italy was effective in punishing the perpetrator, whereas in *Talpis* the criminal law system 'had not had an adequate deterrent effect.'[34] The reasoning of the Court regarding the application of Article 14 ECHR in *Talpis v. Italy* is thus not straightforward. I can argue that the reason lies in the fact that the Court mixed the patterns of discrimination discussed in this paragraph. As pointed out by Judge Eicke in his dissenting opinion, there was no 'appearance of discriminatory treatment of women who are victims of domestic violence on the part of the authorities such as the police, law-enforcement or health-care personnel, social services, prosecutors or judges of the courts of law.'[35] That is precisely the description of a pattern of discrimination in laws and policies of the state: accordingly, either the findings in *Rumor* were wrong, or in Italy this specific pattern of discrimination, which permeates state policies, cannot be demonstrated. The Court was right to state that social and cultural patterns of discrimination are still persistent in Italian society, though. A quick look at Italian newspapers will show, for example, that DV is routinely treated as an 'episode of insanity' by the partner, or a murdered woman's behaviour is scrutinised to find out whether she had cheated on her husband, as this would 'explain' or even 'justify' the act of violence.

In the case under analysis here, though, I can go a bit further, because one element of the facts of the *Talpis* case was not sufficiently discussed by the Court and could have led to identification of a pattern of discrimination by the state. Had it confirmed the existence of such a pattern, not in society but in the behaviour of the state and its organs, the Court could have concluded, in a more effective way, that Italy had violated the prohibition of discrimination as enshrined in Article 14 ECHR. Let us go back to the facts. Talpis had found refuge from her violent husband with a local association. However, after some months, the social services of the municipality of Udine notified the association that no funds were available to guarantee her another refuge or to pay for the refuge found by the association. Talpis then returned home. The government argued that the social services in Udine, which had developed a programme for victims of violence, were not in charge of the situation and therefore could not pay for a refuge managed by

a private association; Mrs Talpis should have contacted the social services to ask for help. The Court could have chosen to apply Article 14 ECHR, and then held that, despite remarkable steps forward in protecting women from domestic violence, the Italian legislative framework *as applied by* the Udine authorities *systematically* discriminated against women.[36] The Italian authorities did discriminate by blaming Elisaveta Talpis for not having asked the competent authorities for help in due time, and by not supporting associations which assist women victims of abuse. This can be defined as a pattern of discrimination preventing abused women from having free and immediate access to social services.

In support of the main argument of these pages, I should also mention the views of the CEDAW Committee in *Angela González Carreño*, which clearly contended that:

> [w]hen there is evidence of systematic patterns of violence against women, or when the incidence of violence against women is inordinately high, as reflected in a high rate of domestic violence, it is clear that the State knows or should know of the risks faced by women who have complained of violence from their partners or former partners.[37]

Furthermore, in a case of rape and abduction, the African Commission stressed how the state does not respect its obligations 'when it tolerates a situation where private persons or groups act freely and with impunity in violation of the rights' under the African Charter.[38]

If we turn to the vertical dimension, the pattern of discrimination can be seen either in laws and policies in the field of health care that directly or indirectly cause VAWH – for example the criminalisation of abortion or provisions on forced sterilisation – or in the state's 'tolerance' of discriminatory behaviours by medical personnel, both in the public and the private sector, which cause VAWH. Hence, for example, in *CGIL v. Italy*, the European Committee of Social Rights argued in 2013, that, despite the law granting women access to abortion, and the monitoring activity started by the government, 'the shortcomings which exist in the provision of abortion services in Italy … remain unremedied.'[39] Another example of a pattern of discrimination taken from the case law analysed in chapter 1 concerns the provision of misleading information to women, either because directly required by the state, the male actor I have referred to several times, which can replace the woman in pivotal decisions concerning her body; or because medical personnel are guided by the stereotype that the woman will always decide to protect her foetus, no matter what medical treatment is necessary to do so. Health personnel, whether in public or in private healthcare, perform a public function in the field of health. With regard to abortion, from a social perspective, as Ronli Sifris has interestingly argued, 'coercing a woman to continue with a pregnancy has the effect of coercing her to become mother.'[40] The direct consequence of doing this is to reinforce a socially imposed construction of a woman's role in society, and to reduce the possibility, given the way many workplaces organise themselves, for her to live a professional life: 'legal restrictions on access to abortion discriminate

against women in [a] myriad of ways. They are formulated and implemented in a social context in which gender inequality reigns.'[41]

The pattern of discrimination in the vertical dimension can be also seen in all cases of involuntary sterilisation. As I discussed in chapter 1, sterilisation without the consent of the woman, or without fully informed consent, can be imposed by the adoption of eugenic laws by the state. In this regard, the CEDAW Committee, in its concluding observations on Japan, noted that 'the State party, through the Prefectural Eugenic Protection Committee, *sought to prevent* births of children with diseases or disabilities and, as a result, subjected persons with disabilities to forced sterilization.'[42] It was a pattern of discrimination, in this case on the ground of disability, by means of a law in the field of health. Several cases of involuntary sterilisation have been reported in many countries, and the ECtHR has handed down pivotal judgments in which it applied the right to respect for private and family life and the prohibition of torture, inhuman or degrading treatment or punishment. Nonetheless, when it comes to the prohibition of discrimination under Article 14 ECHR, as I have already mentioned, the Court has missed the opportunity to tackle these cases as discrimination, and intersectional discrimination more specifically.[43] In *I.G. and others v. Slovakia*, for example, the Court first found that the practice of sterilising women without their prior, informed consent 'affected vulnerable individuals from various ethnic groups,' but then noticed that 'it cannot be established … that the doctors involved acted in bad faith, that the first and second applicants' sterilisation was a part of an "organised policy," or that the hospital staff's conduct was intentionally racially motivated.'[44] Before a decree of the Ministry of Health in 2013, which set out procedures to guarantee that a woman could only be sterilised after free, prior and informed consent, the Public Health Act had allowed physicians 'to deliver the sterilization without the information procedure generally specified when it seems to be appropriate in given circumstances.'[45] The existence of a pattern of discrimination, at the time when sterilisation occurred, seemed to be confirmed by the most recent report of the UN Committee on the Elimination of Racial Discrimination (CERD) in Slovakia, which, with regard to the right to health, expressed its concern 'about reports of discriminatory treatment by medical personnel against Roma and segregation of Roma, particularly women and girls, in different hospital departments.'[46] The Committee acknowledged that, despite the measures adopted to prevent forced sterilisation, access to justice for those who suffered involuntary sterilisation still remained difficult.[47] Where women belong to minorities, the woman's body is 'used' to discriminate against an entire group, and women are considered as 'incapable of making rational decisions.'[48] Why not promote campaigns of contraception or sterilisation for men? Ronli Sifris has clearly answered this question:

> If a woman's body belongs to the men in her life and the male paradigm of the State, then it is logical that involuntary sterilisation procedures should be carried out on women more than men, even though the medical procedure for men is much simpler than that for women.[49]

The relevance of intersectionality in describing patterns of discrimination

The term 'intersectionality' was first introduced by Kimberlé Crenshaw in the late 1980s, to stress the specific conditions of Black women in US society. It is not a concept that applies only to marginalised groups, it is rather 'an aspect of social organisation that shapes our lives,' with the consequence that 'groups may be advantaged or disadvantaged by structures of oppression.'[50] Intersectionality has not had much attention in legal scholarship, though. Defined as an 'analytical tool,'[51] it has rarely been invoked in court. In these pages, I use the definition of intersectionality proposed by Lorena Sosa, who, in her remarkable book, considers intersectionality 'a tool for interpreting human rights in general, and for violence against women in particular, consisting of an explicit interdisciplinary approach to the study of race, gender, class and other social categories of distinction.'[52] This idea, she argues, captures the 'socio-structural nature of inequality.'[53] From a legal point of view, intersectionality can be used as 'interpretative methodology' for exploring international legal norms on VAW,[54] and for 'empowering these norms.'[55]

Why is intersectionality appropriate for conceptualising the idea of VAWH? Although the issue of intersectionality has mainly emerged in connection with involuntary sterilisation, intersectionality permeates all the types of violence that I proposed in chapter 1. Starting from the horizontal dimension, in cases of DV the 'tolerance' of the state for episodes of DV, manifested in lack of or delay in investigation, and absence of effective remedies, can become more intense in all cases in which the woman belongs to a minority. Hence, for example, in *Lenahan (Gonzáles)*, *amici curiae* presented several reports during the proceedings before the IACommHR, one of which precisely concerned the effects of DV on minority women and children and the law enforcement response.[56] Even though the Commission, deciding the case, did not consider intersectionality as an issue in its report, it stressed the existence of multiple grounds of discrimination, recognising that 'certain groups of women face discrimination on the basis of more than one factor during their lifetime, based on their young age, race and ethnic origin, among others, which increases their exposure to acts of violence.'[57] This has consequences in terms of measures that the state must adopt in order to change socio-cultural patterns of discrimination.

Intersectionality is relevant when a woman is raped, because she is a woman, and because she belongs to a specific minority. The decision of the IACHR in *Inés Fernández Ortega v. Mexico* is an example in that respect. The Court elaborated the state's obligation to guarantee access to justice by referring to the specific situation of indigenous women. As I will elaborate further, the pattern of intersectional discrimination in cases of FGM/C seems much more apparent in state reactions to such cases than in reactions to other violations of a woman's physical integrity.[58] Without denying that FGM/C is a form of VAWH, as I will contend, the response of the state to these violations of women's rights to health

and reproductive health has proved to be discriminatory, especially against *adult* women belonging to minorities in which this practice is performed.

Turning to the vertical dimension, from the *anamnesis* elaborated in chapter 1 I can draw several cases of intersectional discrimination. It seems that another ground of discrimination is specifically relevant to access to abortion, for example: the social and economic conditions of the woman seeking such access. When access is withheld because abortion clinics do not exist in the area where the woman lives,[59] or because practitioners opt for conscientious objection,[60] or because the fees are too high,[61] or because the law does not allow women access to abortion and they are obliged to travel,[62] it is evident that these health laws and policies cause VAWH, and their impact is much more severe for those who do not have the economic means to gain access to safe abortions. Unsafe abortions are extremely dangerous for women's health.

Ethnicity as a ground for discrimination combined with gender is seen both in cases of involuntary sterilisation, and in cases of OV. Going back to its recent report on Slovakia, CERD affirmed that it had received information relating to 'verbal and physical violence faced by Roma women when accessing sexual and reproductive health services.'[63]

The *anamnesis* was particularly useful in highlighting how some courts, in particular the ECtHR, have been reluctant to apply the concept of intersectional discrimination, or, despite recognising the existence of different grounds of discrimination, have not drawn adequate conclusions about the state's obligations. In its GR No. 35, the CEDAW Committee acknowledged that 'because women experience varying and intersecting forms of discrimination,' VAW 'may affect some women to different degrees, or in different ways, so appropriate legal and policy responses are needed.'[64] This means, in other words, that intersectionality, far from being a mere feminist naïveté, is fundamental to accurately identifying states' obligations, such as the obligation to provide access to effective remedies. In my analysis of VAWH, the concept is especially pertinent because intersectionality particularly matters in the field of health policies and laws, with regard to women's rights to health and to reproductive health, and it matters in both dimensions of violence explored in this book.

As I will show further in chapter 3, the notion of intersectionality allows us to reflect on the 'costs' of services for women. Should emergency contraception be free? Should access to abortion be covered by health insurance? What about the differences in access to health and social services for poor women and women belonging to minorities? I am referring not only to the US system, characterised by a system of private insurances, but also, for example, to travel insurance. Without mentioning any particular company (since I am sure similar provisions appear in many contracts), a travel insurance purporting to cover costs related to injuries and illnesses while abroad clearly excludes 'voluntary termination of pregnancy,' 'assisted reproduction' and 'related complications.' Accordingly, a woman who seeks abortion outside her home country has to bear all the costs of the procedure plus the risks deriving from possible medical complications.

VAWH as a form of gender-based violence

Violence against women, as repeatedly confirmed in international and regional legal instruments alike, is based on gender. VAWH is also gender-based, because, to quote GR no. 35 adopted by CEDAW in 2017, it is founded on stereotypes rooted in our societies, it is a 'social – rather than individual – problem, requiring comprehensive responses, beyond specific events, individual perpetrators and victims/survivors.'[65] The Council of Europe Istanbul Convention also 'link[ed] gender-based violence to gender stereotypes,'[66] and the expression of gender-based violence is understood 'as aimed at protecting women from violence resulting from gender stereotypes.'[67]

A stereotype is 'a generalized view or preconception of attributes or characteristics possessed by, or the roles that are or should be performed by, members of a particular group (e.g., women, lesbians, adolescents).'[68] Stereotypes are ancient and persistent. They are ancient – it is possible to find traces of them in literature and in popular idioms. Bruna Bianchi argued that DV is 'widespread in all social classes and cultural contexts, invisible, silenced, condoned, often the object of complacent humour which crystallised in popular idioms, songs and nursery rhymes.'[69] As early as the beginning of the nineteenth century feminists started to fight against stereotypes that depict women as vulnerable, incapable of taking autonomous decisions and completely dependent on their husbands or male relatives. Stereotypes are persistent because, for all that feminists could achieve excellent results in promoting gender equality in the law, VAW and VAWH characterise all societies of today. As has interestingly been argued, 'when a State applies, enforces or perpetuates a gender stereotype in its laws and policies, it institutionalises the stereotype giving it the force and the authority of law and custom.'[70]

Stereotypes can be seen in all the cases I analysed in chapter 1. As with the cases of intersectional discrimination, human rights courts have not always been ready to construct their arguments on the existence of stereotypes. UN treaty bodies have demonstrated themselves more attentive in assessing the existence of stereotypes in cases of VAW. For example, in *A.T. v. Hungary* the CEDAW Committee referred, in a case of DV, to the 'persistence of entrenched traditional stereotypes regarding the role and responsibilities of women and men in the family.'[71] In the views on a rape case, *Vertido v. The Philippines*, the CEDAW Committee stressed that:

> the judiciary must take caution not to create inflexible standards of what women or girls should be or what they should have done when confronted with a situation of rape based merely on *preconceived notions* of what defines a rape victim or a victim of gender-based violence, in general.[72]

In this case, Karen Vertido was raped by a senior colleague after a dinner to which she and another male colleague had been invited. She could not obtain justice, since the national court acquitted the perpetrator on the basis that it was not clear

'why the woman had not escaped when she allegedly appeared to have had so many opportunities to do so.' The stereotype of the woman that must demonstrate resistance to rape or be assumed to have consented to it permeated the national court's judgment. Another gender bias was the court's affirmation that 'an accusation for a rape can be made with facility,' implying that women may lie when it comes to reporting unwanted sexual intercourse.[73] Viewed through the lens of VAWH, rape caused Vertido both physical and psychological harm, which was exacerbated by the re-victimisation she suffered during proceedings in front of the domestic court. The Committee found that the Philippines had violated Articles 2(f) and 5(a) of the CEDAW Convention because the state had failed to respect its due diligence obligations to banish gender stereotypes.[74] The affirmation is particularly strong and not devoid of legal consequences, in terms of actions that the state must adopt to eradicate prejudices.

At first sight we can argue that courts have responded to FGM/C through judgments that, although not always directly, have emphasised the stereotyped role of women in the societies where this practice is performed. Courts have granted refugee status to women escaping countries in which there was a risk of being subjected to FGM/C, a practice that has been defined as 'cultural,' 'barbaric,' 'torture.' These judgments must be welcomed, although I will try to go a bit further in the analysis. I am convinced that, even though it is practised by women, and has a ritual and ancestral meaning, FGM/C is a form of VAWH, which entails severe consequences for women's and girls' health and reproductive health. It is based on stereotypes that identify a specific role for women in society. Nonetheless, as I will discuss further, courts themselves, while condemning FGM/C, and while accepting requests for refugee status, perpetuate stereotypes. If we look at the language used by the courts, this argument is crystal-clear. The Constitutional Court of Uganda, in the pivotal case *Law and Advocacy for Women in Uganda v. Attorney-General*, condemned FGM/C by also referring to Article 33(1) and (3) of the Ugandan Constitution, which states that 'women shall be accorded full and equal dignity of the person with men,' and that 'the state shall protect women and their rights taking into account their unique status and natural maternal functions in society.'[75] This assumes that the state can better protect women, since they occupy a condition of vulnerability. I am not arguing that national courts should not have condemned the practice, quite the contrary; but when it comes to my paradigm and my notion of VAWH, I cannot disregard practices that, despite having similarly permanent and dangerous effects for a woman's health, are accepted by society without any – or with very little – concern. Fighting stereotypes using other stereotypes of women does not seem the most adequate approach to identifying and eradicating the rooted causes of VAWH.

The vertical dimension shows many examples of stereotypes. The recurrent stereotype of the mother who cannot decide what is best health practice for her child and herself is pervasive. One author calls it the 'ideology of motherhood,' which may lead to prohibitions on contraception and abortion, and is characterised (given the stereotyped role of women as caretakers) by a lot of emphasis

on, for example, 'the importance of breastfeeding for children's nutrition, the bond between mother and child established through pregnancy and women's sensitive and caring nature.'[76] The CEDAW Committee examined a tragic case of lack of access to abortion, and acknowledged for the first time 'the impact of stereotyping on the rights of individual women.'[77] In *L.C. v. Peru*, the stereotype was to regard the woman as a vessel for reproduction, letting the interests of the foetus prevail over those of L.C. This stereotype caused a doctor to delay the decision to perform spinal surgery on a minor who had been raped and attempted suicide, severely injuring herself. L.C. was also refused therapeutic abortion. Similar stereotypes operate to restrict access to contraception: pharmacists and health personnel in public dispensing have claimed, for example, their right to conscientious objection in refusing to accept requests for contraceptives and refusing to fill a doctor's prescription of contraceptives.[78]

Conversely, involuntary sterilisation goes in the direction of denying women motherhood. The stereotype here sees the woman as not capable of deciding what is the best for her, because she is HIV-positive or because she is a convicted criminal (say), and others – practitioners or the state directly – as better qualified to decide on her behalf. Ethnic biases are particularly prevalent in cases of involuntary sterilisation, as I realised after investigating issues of intersectional discrimination where the state has decided that women belonging to a particular minority must be prevented from having children.

Finally, the stereotype is evident in OV. If a woman's role is to have children, and she is not considered 'complete' without them, one might assume that she will do whatever she is asked to achieve this outcome, without questioning too much the practitioner's opinion: when deciding on an unnecessary caesarean section, say,[79] or manoeuvres or other practices during the birth. The stereotype is also normalised by women, who do not report cases of OV, believing that they are 'normal' practices.

The *anamnesis* confirmed the main arguments in the feminist discourse regarding the female body and the approach of medicine over time. Laura Purdy has contended that the process of 'medicalisation' of women's health, meaning the 'tendency to define normal events in women's lives … and natural states … as pathological and requiring medical attention,' is surely an aspect of our times, but that it cannot be simply demonised. As she pointed out, 'a medical approach to bodily conditions (medicalisation) is not the problem, but rather the culture of medicine itself.'[80]

VAWH as a violation of the right to health and the right to reproductive health

VAWH consists in violations of the women's rights to health and to reproductive health. In the *anamnesis* in chapter 1 my analysis of case law showed that these rights are seldom invoked. The outcome is not surprising. The right to health is not included in the ICCPR, nor in the European and American regional conventions on human rights. The American Convention (Article 5(1)) and the Belém do

Pará Convention (Article 4(c)) provide rights to respect for physical and mental integrity, but do not include the right to the 'highest attainable standard of health' as elaborated in the ICESCR. Accordingly, failure to apply the rights to health and to reproductive health does not suggest that the right to health is regarded as less justiciable, but simply that this right was not envisaged in regional human rights legal instruments characterised by developed monitoring mechanisms of compliance. Courts have referred to the health conditions of the applicant in many judgments, as have UN treaty bodies in their views, and found violations of three major human rights: the right to privacy, which includes the respect for reproductive autonomy; the right to life, in the most serious cases that have led to the death of the woman or of one of her relatives; the right to freedom from torture, inhuman or degrading treatment or punishment.

In cases of DV, the ECtHR has often based its main argument on the physical and psychological conditions of the woman. In *Valiulienė*, as discussed in 'What is violence against women's health?', the Court emphasised the severe mental consequences of DV.[81] In *Opuz*, references to the health condition of Sahide Opuz were relevant to assessing that her right to be free from torture, inhuman or degrading treatment had been violated.[82] Even though the ECtHR cannot apply a right that the European Convention does not convey, it observed that, among the 'factors that can be taken into account in deciding to pursue a prosecution,' authorities must consider 'the continuing threat to the health and safety of the victim.'[83] The IACHR referred to the rights to privacy and to humane treatment in pivotal cases of rape committed by the military such as *Ana, Beatriz and Celia González Pérez v. Mexico* and *Ortega v. Mexico*. The right to privacy includes sexual and reproductive autonomy. In *López Soto* the IACommHR stressed in its report the violations of Linda López Soto's physical integrity, and characterised her kidnapping, and the sexual assault she suffered, as 'expression of acute cruelty … of an extreme intensity', violating her rights to humane treatment, personal liberty, privacy, autonomy and dignity.[84] The protection of personal integrity was also mentioned by the Municipal Court of Pueblo Rico in a case of FGM/C within the Emberá-Chamí indigenous community.

Turning to the vertical dimension, the rights to personal integrity and to freedom from violence were mentioned in the report of the IACommHR in the case *Manuela y Familia v. El Salvador*, regarding a woman who was imprisoned after having a miscarriage and died while in detention.

The lack of access to abortion has been examined under several provisions of both the ECHR and the ICCPR, and the aspects relating to health have been mentioned in order to support conclusions that a specific right had been violated. In *Mellet,* for example, the HRC highlighted the 'high level of mental anguish' Amanda Mellet suffered. In *Tysiac v. Poland*, the ECtHR referred to the 'terrible anguish' Alicja Tysiac, who was refused abortion, was subjected to, while in *R.R. v. Poland* it applied for the first time Article 3 ECHR in a case which resembled *Tysiac* in terms of the obstacles to gaining access to abortion services. With no right to health, but referring to the health consequences of violence, the Court

has relied on other human rights to ascertain the effects of violence on women's health.

Some national courts have directly applied the rights to health and to reproductive health in cases brought to their attention. For example, in the C-355/2006 judgment, the Colombian Constitutional Court ruled that a law criminalising abortion in all circumstances was unconstitutional. In particular, it argued that women's right to health encompasses reproductive health, including freedom from state interference in women's decisions. The Supreme Court of Nepal applied the constitutionally granted right to health in *Lakshmi Dhikta*, which concerned economic difficulties in gaining access to abortion.

At national level, the rights to health and to reproductive health were also mentioned in the *G., M.C.Y. v. Hospital Luis Lagomaggiore* judgment on OV decided by the Court of Mendoza in Argentina, and by the High Court of Delhi in a case regarding maternal mortality.[85]

At regional level, it is worth mentioning the decision in *CGIL v. Italy*, where the European Committee of Social Rights applied the right to health in the analysis of the *de facto* difficulties in gaining access to abortion services attributable to the number of conscientious objectors operating in Italian hospitals. The mechanism of collective complaints provided by the European Committee, although unique, is not capable of filling the gap in the jurisprudence of the ECtHR where social and economic rights are not protected in its founding treaty, however.

At the international level, needless to say the CEDAW Committee has offered the best protection of the rights to health and to reproductive health, given that its governing convention includes the principle of non-discrimination in the field of health care (Article 12(1)), and obliges state parties to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period (Article 12(2)). Cases such as *L.C.* on access to abortion, *Andrea Szijjarto v. Hungary* concerning involuntary sterilisation and *Alyne da Silva Pimentel Teixeira v. Brazil* on maternal health are excellent examples of the affirmation of the right to health as justiciable. Let us focus on these cases to assess whether the outcome of these decisions was different to those in cases in which the right to health was indirectly applied. If the focus is (only, although importantly) on the right of the victim/survivor to receive justice, and on compensation for the harm suffered because of the violation of human rights, applying the rights to health and to reproductive health, whether directly or indirectly, does not seem to change much, at least at first sight. As one author has argued about a case of DV, 'the inclusion of the right to health may not have changed the outcome of the decision, but it would have provided the Court with a far more honest and accurate assessment of the harms that were suffered' by women.[86] I would say that the outcome would be similar, but not identical. Application of the rights to health and to reproductive health can better shape states' obligations, as I will discuss in chapter 3, in the form of positive obligations to provide health services to women.

The main objection to this argument is that, even if my assertion is so, and application of the rights to health and to reproductive health would change the

outcome of a case, we cannot alter the nature of legal instruments that are the product of the will of the state. It is up to states to amend provisions included in international treaties. One might also object that the cases in which the rights to health and to reproductive health have been applied were brought before either the courts of states whose constitutions include the right to health, or the CEDAW Committee whose founding convention encompasses these rights and whose decisions are not binding. Still, even without specific provisions, the ECtHR and the IACHR, along with the HRC, have been able to address issues of health in their judgments/views. In other words, international and regional jurisprudence has not directly ensured respect for the right to health; rather, it has indirectly *promoted the right's content by applying other, more 'justiciable' rights*. The expression 'more justiciable rights' does not imply different levels of justiciability but that some rights have been more easily applied, owing to the way the complaint has been presented or a body's competence not extending into key areas. This is of interest for my purposes. Until the recent judgment in *López Soto*, the case law of human rights courts has had a 'knock-on effect', upholding individual rights in several articles of the conventions of which they are the guardians, and could pave the way for amendments to those conventions or the addition of new protocols to them.[87] This does not mean 'inventing' new rights or placing excessive burden on human rights courts, but rather implies conceiving a material right that already exists in other legal instruments, and has been the object of interpretation by courts. The future could bring some light and some 'justiciability' to the right to health before UN treaty bodies, thanks to the entry into force of the Protocol to the ICESCR, giving the corresponding committee competence to accept individual complaints against the states that have ratified it (at the moment, few).

Direct application of the rights to health and to reproductive health would have some fundamental consequences. First, even though we can agree with the courts that DV and rape amount to torture, inhuman or degrading treatment or punishment, it is also true that where regional courts get rid of the assessment of the level of intensity their reasoning is not always straightforward. Furthermore, the right to be free from torture, inhuman or degrading treatment or punishment, application of which is almost automatic in cases of DV and rape, is not necessarily applicable in all cases of VAWH. The IACHR has not applied the prohibition of torture in cases of DV or rape committed by private individuals, for example,[88] because of the specific characteristics of the crime of torture.[89] In cases of lack of access to abortion, the first judgment in which the ECtHR applied Article 3 ECHR was handed down in 2011, two years after the well-known *Opuz* judgment on DV.[90] Second, as I will show, the main consequence of considering the violation of the rights to health and to reproductive health concerns states' obligations. Third, application of the rights to health and to reproductive health – the latter as part of the former – will reinforce the justiciability of the right to health, which as a social and economic right has suffered the same status of 'Cinderella right' as the other rights included in the ICESCR. If direct application is not possible, con-

siderations on the right to health and reproductive health should permeate more extensively the legal reasoning of courts and human rights bodies. Fourth, from a feminist legal perspective, this argument would help women, because application of the rights to health and to reproductive health would better emphasise the multiple angles of VAWH, which causes serious physical and psychological harm, and would embrace both the dimensions I discuss in this book. Julie and Sandra Levison have argued that 'although violence and abuse are an integral part of the lives of many people, and the single greatest cause of injury to women, the subject of violence has not been systematically addressed as a major issue in women's health.'[91] They refer to data and national surveys, but I realised in my research how the rights to health and to reproductive health have only been protected indirectly, and how they would play a fundamental role in enhancing the protection of women's rights at the international level. As was reported in a manual of the National Academy of Women's Health, women's health:[92]

> includes the values and knowledge of women and their own experience of health and illness; recognizes the diversity of women's health needs over the life cycle and how these needs reflect differences in race, class, ethnicity, culture, sexual preference and levels of education; includes the empowerment of women … to be informed participants in their own health care.

VAWH and intent

In the short analysis of the definition of VAW contained in the introduction,[93] I argued that intent is not a necessary element of the definition, and that VAW can be conceived as a framework encompassing acts of gender-based violence against women rather than a distinct crime or behaviour. I have already shown in this chapter that VAWH grasps both dimensions of violence, and describes well the relationship between VAW on one hand, and the rights to health and to reproductive health on the other. I will confirm the absence of the element of intent in the definition of VAWH conceived in this book, and further explore an element that I outlined in 'VAWH as a form of discrimination against women: patterns of discrimination', namely the 'pattern of discrimination' that can be found in both dimensions of violence.[94]

I am not discussing here the concept of intent in criminal law, which goes beyond the scope of this book, and would require a comparative analysis of different legal systems and of international criminal law.[95] Intention, in a very simple and clearly non-exhaustive summary, is related to the purpose of an action. It is the 'guilty mind' of the perpetrator.[96] It could be said that the purpose of VAWH is to discriminate against women because they are women. Nonetheless, discrimination is structural, and permeates societies to the extent that it might be difficult to prove that an individual and/or the state intended to discriminate against women while committing an act of violence. VAW, and VAWH as it is conceptualised here, *is* defined as a form of discrimination against women. In other words, acts of violence may not aim to discriminate against women,

but *constitute themselves* forms of discrimination, are directed against women because they are women and/or affect women disproportionately.

The concept of intent is extremely complex in international law, especially when it concerns states. Could a state have a 'guilty mind'? As put by Ronli Sifris, who interestingly has analysed limitations to reproductive freedom from the point of view of the crime of torture, 'when a State legally restricts access to abortion, can it be viewed as intending to cause severe pain or suffering'?[97] Relying on an argument made by Rhonda Copelon,[98] she concluded that, since severe pain and suffering is 'a foreseeable consequence of both involuntary sterilisation and restrictions on abortion,' the requirement for intention is 'satisfied in both of these cases.'[99] This analysis is of utmost interest. Nonetheless, it has proved very difficult not only to consider intention on the part of the state, a collective entity,[100] but also to examine state responsibility for the sole exercise of the legislative power.[101] Furthermore, the responsibility of the individual must be distinguished from the responsibility of the state. As I have argued with regard to genocide, if we consider the state as a *de facto* entity, we might say that it has a 'guilty mind', although intention would manifest itself in a different way: not as 'mental, individual status,' but rather as 'state policy' and a 'pattern of conduct.'[102]

Let us consider a case taken from the vertical dimension. When a practitioner communicated misleading information to a woman seeking abortion, was there an intent to cause VAWH as a form of discrimination against women? From the point of view of the responsibility of the individual, the analysis should be conducted in terms of medical malpractice litigation, and it would lead to the assessment of the 'negligence' of the practitioner rather than of the intentions.[103] This level of analysis is not relevant here, however, because I am not discussing the intent of the perpetrators of the single actions that can be referred to VAWH, but the intent – or the lack of intent – in the concept of VAWH itself. Since VAWH is not conceived as a distinct crime but as a framework, the analysis of intent seems superficial. Nonetheless, the *anamnesis* suggests that a 'pattern of conduct' by the state, in my case 'a pattern of discrimination,' exists in all cases of VAWH intended in its vertical dimension, and whenever a repeated tolerance is demonstrated in the horizontal dimension. The 'pattern of conduct', in other words, associates both dimensions as conceived in this book. This argument will prove useful in elaborating states' obligations, in particular the policies and laws that must be adopted in the long term to eradicate violence, and will emphasise the importance of the principle of non-discrimination in human rights cases.

In *Opuz*, the ECtHR contended that there was no need to prove intent while assessing state responsibility for violating Opuz's human rights in a case of DV.[104] However, while deciding whether Turkey had violated Article 14 ECHR, the Court referred to the general attitude of the authorities, and concluded that it had.[105] I saw that the ECtHR has not demonstrated in all cases a structural tolerance by national authorities investigating cases of DV.[106] In a case on involuntary sterilisation, hence concerning the vertical dimension, *I.G. and others v. Slovakia*,

the Court argued that there was no evidence that the practitioners had acted in bad faith or that sterilisation was part of an organised policy, and it did not proceed to investigate the case under Article 14 ECHR. In this case, however, a pattern of discrimination could have been demonstrated, given a long-standing attitude in the health sector to discriminate against Romani people.

Considering the vertical dimension, it should be said that, directly or indirectly, the pattern of discrimination can be showed in all cases in which health laws and policies cause VAWH: directly, when the law itself causes VAWH, for example by criminalising abortion; or indirectly, for example when, despite a law granting access to abortion, services and practitioners responsible for a public interest activity (in the field of health care) *do* cause VAWH. Back in the 1980s, one author contended that, in the United States, 'legislative proposals to allow involuntary sterilisation of certain groups on eugenic grounds have a long history,' and the public policy showed 'a systematic, state-sanctioned character of involuntary sterilisation,' which was later replaced by sterilisation programmes 'more subtle but nonetheless motivated by population control objectives.'[107] The only context in which it seems that the pattern of discrimination cannot be demonstrated is when the individual's action is not related to any form of policy of the state or the structure, e.g. hospital, for which he/she works.

In the horizontal dimension, a pattern of discrimination can be verified, as human rights courts have underlined, when the state shows 'tolerance' for acts of gender-based violence. Is 'negligence' showed by organs of the state sufficient to demonstrate state responsibility for VAWH? Where pain and severe suffering are the consequences of negligence, the requirements for considering an act as torture are not met (because to be torture, there must have been an intent, and a very strong one). In other words, negligence is not enough to demonstrate that torture has been committed.[108] Nonetheless, I would argue that negligence by state organs might be sufficient to prove state responsibility for VAWH because of the existence of a pattern of discrimination against women. By tolerating violence or by promoting policies that perpetuate the subordination of women in society, states repeatedly 'tolerate' a form of discrimination against women and, to paraphrase the ECtHR in a case of domestic violence, create 'a climate that [is] conducive' to VAWH.[109]

Consent and autonomy in the concept of VAWH

The conceptualisation of VAWH does not seem complete without exploring the issue of the woman's consent (or lack of consent), which is not, *prima facie*, part of the definition. The concept of VAW, as elaborated in international and regional legal instruments, does not refer to consent either. However, consent is relevant for both the horizontal and vertical dimensions: lack of consent is an element of the offence of rape, just as lack of 'informed' consent characterises, for example, forced sterilisations.

Consent is an expression of autonomy, and 'autonomy is self-determination.'[110] Francesca Rescigno has defined self-determination as 'a fundamental right,' which is not expressive of 'egoistic liberty,' but rather an 'aware [and informed] choice of the individual within a community and not against it.'[111]

In its GC No. 22, the ESCR Committee considered the right to sexual and reproductive health as 'indispensable to [women's] autonomy.'[112] As argued by Erin Nelson, autonomy is 'the ability to be self-determining and to act on one's own values in making decisions about reproduction.'[113] Autonomy is a pivotal concept in philosophy, bioethics and law; as outlined by Sheila McLean, it is 'the transcending principle of modern bioethics.'[114] Marilyn Friedman contends that autonomous choices are self-reflecting, in the sense that, on one hand, they are caused by a woman's 'reflection on wants and desires that characterise her,' and on the other hand they must reflect wants, desires, cares, values and commitments that someone reaffirms when attending to them.[115] Autonomy is, for the purpose of this analysis, the capacity of a woman to decide about her health, and her reproductive health more specifically.

There is a huge literature on autonomy, from different perspectives.[116] From a philosophical and ethical point of view autonomy would be of utmost interest to discuss, but I cannot even attempt to do it justice here. The purpose of this sub-section is not to dwell on all the existing theories on autonomy, but to assess how consent and autonomy matter for conceptualising the idea of VAWH, and how these are cross-cutting issues for both dimensions. A few preliminary notes seem useful, however.

Individualistic accounts of autonomy have prevailed since 'the change of emphasis' from paternalism, which was common in ancient medicine, to autonomy.[117] In the 1970s, feminists stressed how this notion of autonomy expressed a 'liberatory potential for women.'[118] Nonetheless, individualistic autonomy has been accused of disregarding social context, the network of duties and obligations, and relationships and interests, of the community.[119] This is why scholars, and feminist scholars in particular, turned in the 1980s, and more clearly in the 1990s, to a relational concept of autonomy, considering women as embedded in social relations. Hence, for example, Carol Gilligan, who theorised the 'different voice' of women characterised by responsibility for 'others,' saw care as complementary to individualistic autonomy.[120] Interpersonal relations were at the core of her reasoning. Susan Sherwin, who discussed this issue ten years after Gilligan, did not consider merely interpersonal relations, but rather, and to a great extent, 'the full range of influential human relations, personal and public.'[121] She elaborated a concept of relational autonomy, which was based on the understanding of 'how forces of oppression interfere with an individual ability to exercise autonomy.'[122] Her perspective belongs to radical feminism, which has repeatedly highlighted the limited control women have over healthcare institutions. Without denying the importance of the individual decision, relational theories show 'the damaging effects on autonomy of internalised oppression.'[123] In other words, what is internalised is structural *and* individual, pertains to society and is interi-

orised by the individual. In the words of Simone de Beauvoir, 'a free individual blames only himself for his failures, he assumes responsibility for them; but everything happens to a woman through the agency of others, and therefore these others are responsible for her woes … she insists on living in her situation precisely as she does – that is, in a state of impotent rage.'[124] In other words, anyone has a 'choice', but the constraints that shape women into women 'can make it virtually impossible for them to exercise this freedom in the world.'[125] Relations are therefore fundamental to understanding the patterns of oppression of women. Relational, in the understanding of Sherwin, means 'contextualised,' or 'socially situated.' In both individualistic and relational autonomy, Sherwin highlighted the importance of informed consent, which, in the case of her account of autonomy, must take into consideration the social location of the woman, and how this location can affect her autonomy.

Susan Dodds, more recently, followed the relational approach. Unlike Susan Sherwin, however, she reconceived the idea of consent, suggesting that 'an adequate understanding of respect for autonomy in health care must extend to an understanding of the development and exercise of the capacity for autonomous decision-making, rather than focusing solely on informed consent or even rational choice.'[126] Even though a person may have all the information she requires, this fact does not guarantee autonomy. The woman must have 'autonomy competencies' to determine 'how to choose authentically.'[127] Accordingly, what is needed is a process of counselling that helps a woman determine what she wants in the given context; this process should assist the person to 're-examin[e], when possible, one's preferences, goals, values.'[128] This theory, although interesting, especially when it reflects on the capacity to decide critically, is not devoid of criticism. Erin Nelson, for example, contends that the adjective 'relational' is unhelpful and might be risky, since 'it can be understood to mean that if you are not in the right kinds of relationships … you cannot be autonomous.'[129] It might lead to an effect that contradicts the initial purpose of countering oppression, by 'justifying paternalistic ideas and arguments about which decisions can legitimately count as autonomous.'[130] Furthermore, the activity of 'counselling' that Susan Dodds recommends can be in itself biased by stereotypes which might well have been internalised by the practitioners. I agree with Nelson when she endorses a 'social' conception of autonomy, which reconciles individualistic choice with feminist recognition of the reality of oppression, without entirely embracing the relational approach.[131]

Based on the right to autonomy is the doctrine of consent, which implies that 'decisions must be made following the provisions of information by a competent, non-coerced individual and [one] may even expect to see some evidence that the person has understood the information they have been given.'[132] The law on consent varies from country to country, but a general principle is encapsulated in the 1997 Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Oviedo Convention), under which an intervention in the health field 'may only be carried

out after the person concerned has given free and informed consent to it' (Article 5). Furthermore, according to the Declaration adopted by the General Conference of UNESCO in 2005, 'any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information' (Article 6). The meaning of 'adequate information' was clarified in the report on consent submitted by the International Bioethics Committee of UNESCO in 2008, which identified the following elements to be taken into account to show the consent of a patient to a medical intervention:

- the diagnosis and the prognosis;
- the nature and the process of the intervention;
- the expected benefits of the intervention;
- the possible undesirable side effects of the intervention; and
- possibilities, benefits and risks of alternative interventions.[133]

McLean has interestingly argued that, even though in theory consent *does* represent autonomy, when translated from ethical rhetoric to legal reality it seems to be a rather empty vehicle 'to protect doctors from liability.'[134] According to the theories on autonomy that I proposed, consent does not automatically guarantee autonomy, and I will unravel the problems inherent in both the individualistic and the relational approach by explaining how consent and autonomy matter in conceptualising the idea of VAWH. Before elaborating an autonomous notion of autonomy that, for the purpose of this research, will be 'contextualised' and 'human rights-based,' let us see how consent operates in the horizontal and in the vertical dimensions.

Consent and autonomy in the horizontal dimension

In the horizontal dimension that I have elaborated in this book, encompassing cases in which VAW within interpersonal relationships causes a violation of women's rights to health and to reproductive health, the lack of consent is the key aspect. When a woman endures FGM/C, rape or DV, she loses autonomy in the field of reproductive health, either because the practice permanently and severely affects her reproductive capacity or because, as with DV, her capacity to make decisions is impaired by the pressure coming from the violent partner.

Domestic violence

DV diminishes women's autonomy.[135] Nonetheless, the limitation of autonomy is not solely the result of the actions of the perpetrator. The authorities must intervene when a woman reports an episode of violence, but what happens if the abused woman wants to return to live with her abuser or when she withdraws her complaint to the police? Should the authorities disregard her consent, and act for her well-being?

The analysis in this area by Friedman is relevant for my purposes. She warned against posing the question why women stay, which patently blames the victim, and to turn it over: why do men abuse women?[136] On one hand, reasonable factors might lie behind her decision to stay, including the coercive environment in which she lives, the fear of losing custody of her children, incapacity to survive without the husband's financial resources. On the other hand, however, religious or moral norms might guide women to misunderstand what is happening to them.[137] According to Friedman, failing to prosecute the abuser would increase the risk of future abuses, and the negation of autonomy in the short run will be replaced by autonomy in the long run.[138] Nonetheless, to achieve this objective, authorities and police forces need to be adequately trained to avoid secondary victimisation, and act in a gender-sensitive way.[139] This disrupts the public/private divide: it means bringing DV into the public sphere, and criminalising behaviour that in the past only occurred within the husband–wife relationship. The disruption of this divide 'comes [at] a price,' namely loss of control over the legal consequences that follow DV, and short-term loss of autonomy.[140] From another perspective, however, even in the short run there is no lack of autonomy. Privacy, as Meyersfeld has interestingly pointed out, 'cannot be understood merely as the right to be left alone; rather, it is linked affirmatively to liberty, the right to autonomy and self-determination;' it means, in other words, that 'privacy is not in opposition to, but is an affirmation of, women's safety in the home.'[141] Technologies might be of help in that respect: for example, bracelets or wristbands can be designed to be life-saving devices, capable of detecting situations of danger for a woman who has already reported to the authorities episodes of violence, or has approached a women's rights association.

Rape

As I proceeded with the *anamnesis*, I saw how relevant the lack of consent is in cases of rape.[142] In *M.C. v. Bulgaria*, the ECtHR clearly argued that state practice demonstrates how lack of consent is the pivotal element of the crime in the majority of national criminal law systems, and how rape is a violation of sexual autonomy. In international criminal law, the *Elements of Crimes* of the International Criminal Court (ICC) provide that the crime against humanity of rape occurs when 'the invasion was committed by force, or by threat of force or coercion … or by taking advantage of a coercive environment, or the invasion was committed against a person incapable of giving genuine consent.'[143] Accordingly, proofs of non-consent are 'irrelevant in a context of inherent coercion.'[144] Theories of relational autonomy help us to understand the social context in which rape occurs, both in times of peace and in wartime. Requiring the 'utmost resistance' by the victim, as some judges have done,[145] means completely disregarding the role of women in society, trapped in a network of relations characterised by oppression. As for marital rape, it has only recently been considered from a legal point of view, and not by all countries, as a crime. Relational autonomy might explain why consent has been presumed, precisely because the relation between husband

and wife is supposed to imply consent. Nonetheless, minimal requirements for providing valid consent to sexual intercourse must be 'an assurance of a certain level of freedom, so that consent is not the result of either wrongful threat or oppression.'[146]

FGM/C

It is easy to say that girls a few months old who undergo FGM/C cannot express their consent to it. It is the family that decides for them. Nonetheless, there might be cases in which adult women ask to be re-infibulated after, for example, giving birth to a child. The key issue is then whether the consent of the woman is enough in these cases to authorise the practice. In other words, is the woman's consent expressive of her autonomy? If we consider the relations within which the woman is situated, it can be argued that the community and/or the family can significantly influence a particular decision, and even impose it. It would be possible to contend, following the interesting position elaborated by Sherwin, that oppression is internalised and that it is difficult to consider the genuine nature of the consent within the context of a network of existing (presumably oppressive) relations. However, the criticism to the relational approach proposed by Erin Nelson is especially relevant here. We risk endorsing a patriarchal and Western approach, which decides which relations are the best for the woman: the norms within the society of the host state prevail over those of the society of the country of origin. Although harm to young women's genitalia is never acceptable, regardless of how 'minor' the injury, because harm, as I explained, can also be psychological, and these practices affect a girl's rights to health and to reproductive health,[147] it is important to reflect on the possibility that the woman can give consent when she is adult. Some scholars might find this possibility unacceptable, but I think that it is not when we challenge the relational approach in order to avoid imposing a 'model' of autonomy which belongs to Western countries. For example, in the UK a case of re-infibulation requested by a woman after childbirth ended with the practitioner being acquitted, and this happened despite the strong legislation against FGM/C in force in the UK.[148] The judgments on FGM/C that I discussed in chapter 1 were actually based on 'relations,' because courts from different countries took into consideration the degree of oppression for women in their country of origin. In the majority of the interesting judgments I found, domestic courts accepted requests for refugee status filed by women who might have been subject to FGM/C if returned to their home country. From a legal point of view, and according to my analysis, the arguments were correct, because FGM/C does cause VAWH.[149] In all of these cases the woman refused consent to the practice, and escaped her country of origin. Nonetheless, there is a 'tendency to make "culture" more important than it is in explaining events in non-Western or minority cultures, whilst minimising its significance elsewhere.'[150] European and American societies call 'culture' something that 'we cannot otherwise understand.'[151]

Let us take for example another practice, genital cosmetic surgery (GCS). I can easily contend that it is culturally embedded in Western societies. Genital cosmetic surgery usually consists in labiaplasty, which means to reduce the size of the labia minora – the flaps of skin either side of the vaginal opening.[152] One might say that the woman consents to GCS, and that the practice does not affect new-born girls, so FGM and GCS are not comparable.[153] Nonetheless, in the United Kingdom, girls as young as 11 request the operation.[154] On its website the National Health Service says that the surgery *should not* be performed on girls younger than 18, but it is not prohibited on minors *per se.* This operation is also called 'designer vagina surgery,' which clearly stresses that, in the great majority of cases, it is unnecessary (there is no medical indication of its usefulness) and harmful (because it causes bodily injury). How genuine, meaning devoid of any form of actual or internalised oppression, is the consent of girls as young as 11 that do not like their genitalia and ask for them to be surgically altered? If we go back to relational autonomy, it is clear that the network of relations is fundamental to understanding the complexity of consent. The image of beauty in Western society is 'cultural' in the same sense as a practice that considers FGM/C the act of belonging to a community. Hence, the question is: why should FGM/C be prohibited and not GCS? There is no obvious answer to the question, which surely requires reflection at societal level. For the time being, it can be said that this practice is not often considered from the perspective of human rights law. It should be, just as FGM/C is considered as a violation of human rights. For the purpose of this chapter, I argue that both these practices constitute a form of VAWH. This is why consent matters in the elaboration of the notion of VAWH and in the definition of the offences that belong to this concept. GCS, which causes permanent injuries, can be equated with FGM/C, and should be prohibited when performed on minors who cannot express genuine and well-informed consent.[155] Furthermore, why should a woman, aged 18 or above, not be competent to ask for re-infibulation, but be competent to ask for GCS? A reconsideration of the elements of the crime of FGM/C, including the element of lack of consent, and consideration of when and how GCS violates human rights, would be helpful in addressing cases of VAWH. An adult woman can consent to both practices, and she can even accept that they are part of her group's tradition or a mere standard of beauty; what is relevant here is that she must be aware and fully informed of the consequences for her health so that she can express her genuine, non-coerced, consent.

Consent and autonomy in the vertical dimension

In the vertical dimension, informed consent is the key, as it was in my argument on FGM/C and GCS. As anticipated in explaining the general theories on autonomy, free and informed consent means that a person receives 'adequate information,' including the effects of medical intervention on her health.

Abortion

In terms of consent and autonomy, abortion is a highly controversial issue. What constitutes informed consent in the case of abortion? What information or counselling should a woman receive when deciding whether to undergo abortion? Are mandatory procedures such as transvaginal ultrasounds necessary to 'inform' her? More than in other cases, stereotypes and biases pervade consent in the field of access to abortion. As clearly contended by Cook:

> [t]here is a generalized view that all women should become mothers, irrespective of their distinctive reproductive health capacity and physical and emotional circumstances, or their individual priorities. It does not matter for purposes of defining the stereotype that an individual woman, say Mary, may not wish, for whatever reason, to become a mother. Precisely because Mary is categorized as a woman, it is believed that motherhood is her natural role and destiny.[156]

Stereotypes lead to biased information, which emphasises the foetus's interests at the expense of the woman's. The state, acting as a male actor, protecting the woman from 'wrongful' decisions, engages in 'reflecting what it sees as legitimate social policy,'[157] with the doctor becoming the 'mouthpiece' for state interests.[158]

> With the State and the doctor potentially bearing down on the patient with their own interests in the foetus, how is the distinctly private and individualistic nature of reproductive choice protected?[159]

Describing the situation in the United States, Pamela Laufer-Ukeles explains that doctors 'assume' what the woman wants to know, or should know, in order to take the 'right' decision, about the condition of the foetus and the possibility of foetal pain while performing abortion. Nonetheless, information can be 'unabashedly biased and reflect … ideological interests of the State as long as it is deemed not misleading or untruthful.'[160] In the USA, even though abortion was recognised as a right in *Roe v. Wade*, state laws seek to restrict women's ability to exercise this right through, for example, laws that require pre-procedure counselling with a list of information the physician must provide, laws providing waiting periods between the consultation and the procedure, and laws that oblige the woman to undergo an ultrasound.[161] The stereotype of the relationship between the woman (as potential mother) and the foetus is at the basis of this legislation, with the consequence that the gender dimension of discourses on abortion has been 'eclipsed, more specifically, by metaphysical or otherwise non-legal discourses that focus on the beginning of human life and the protection it deserves.'[162] Jennifer Hendricks considered the 'challenge' as being to 'assign appropriate value' to the relationship between the woman and the foetus 'without becoming deterministic about women's roles.'[163] Sheilah Martin contended that, when the law talks about 'foetal rights' or 'doctor knows best,' pregnant women are placed in 'a separate category, where their rights are frequently denied.'[164] Laufer-Ukeles suggested a relational perspective on informed consent, focusing

on discussion, dialogue and 'the need to interact and understand the competing interests, influences and social pressures involved.'[165] She warns against denying the importance of the relationship, and focuses on the need to recognise the status of pregnancy 'for the purpose of supporting the pregnant person's autonomy and dignity, and to protect the unique relationship, not to undermine the woman's personhood for the sake of the foetus that grows inside her. The context and purpose of recognizing pregnancy matters.'[166] Accordingly, 'ignoring the interdependency and focusing on a woman's full individual autonomy does not enable consideration of the support women need during pregnancy both for their own sakes and for the sake of the foetus.'[167] Greasley interestingly pointed out that the foetus 'cannot partake in international relations of any kind … as can the neonate,' and that the foetus's engagement with the world is 'mediated through the body of the pregnant woman.'[168] Nonetheless, as argued by McLean, a more relational account of autonomy 'would see the pregnant women as intimately linked to her social network, perhaps especially to her embryo/foetus,' with the consequence that women 'should always and at all times act for the benefit of their foetuses.'[169] This route leads us to the elaboration of a notion of human-rights based autonomy: 'the relational account … may result in the deprivation of fundamental freedoms;' it means that women need equal rights, in particular 'the right not to have treatment (or punishment) imposed upon them in the purported interests of their embryos/foetuses.'[170]

In the judgments that I analysed in chapter 1, courts rarely took a position on the status of the embryo, hiding behind the wall of the state's margin of appreciation (ECtHR), or avoiding any reference to women's rights, by preferring to measure a state's provision for abortion against other standards (the undue burden in US jurisprudence, for example). In some cases, judgments have even caused VAWH, such as in *T., S. v. Gobierno de la Ciudad de Buenos Aires*, where abortion of an anencephalic foetus was admitted as 'premature delivery' with the obvious consequence of its death, and severe psychological harm for T. Accordingly, 'some women's lives [and health] have been effectively ruined by the law's failure to hold to the autonomy rights of individuals.'[171]

I anticipated in chapter 1 the sensitive ethical issue that lies beneath every legal discussion on abortion. The relationship between the pregnant woman and her foetus has been depicted as 'maternal/foetal conflict,' stressing the element of hostility. Put in this way, however, this 'conflict' might mean that the woman and her foetus are considered as two separate biological entities. It is not a matter of biology, though, but rather a decision that the legislator or courts can make, to 'highlight either foetal differentiation from, or connection to, the woman.'[172] The difficulties consist in the prevalence of 'non-legal arguments on abortion,' which 'place abortion discourses beyond the law's grasp, couching it in terms that appear to be non-negotiable for the law and that sit uncomfortably with modern legal arguments.'[173] If we follow the legal reasoning, it is possible to argue that the embryo has a 'status' – and we can even say a gradual status that grows week after week[174] – but it is not a holder of rights, at least according to the legal

instruments in force and state practice. As outlined by Laufer-Ukeles, 'the full set of rights and interests of personhood begins at birth despite political, religious and humanitarian desires to protect foetal life.'[175] Having a status means that it is more than a simple group of cells, as described by the Committee of Inquiry into Human Fertilisation and Embryology (Warnock Committee) in 1984,[176] but that its interests cannot prevail over those ones of its mother. Birth is the turning point: 'a cataclysmic event [that] propels the foetus into the context in which it can … be brought into membership with other human beings.'[177] Moving to my concept of VAWH, I can argue a bit further that its interests cannot prevail when the lack of access to abortion causes VAWH. When state policies in the field of health directly or indirectly cause VAWH as conceptualised in these pages, the rights to health and to reproductive health of the woman must guide the reasoning. VAWH occurs, for example, when the woman cannot have access to abortion despite severe foetal impairments, or when her life and/or her physical and psychological health are at risk, or when she encounters insurmountable difficulties causing her anguish and psychological pressure. Using the paradigm elaborated in this book, it is not a conflict between the foetus and the mother that must be resolved. States *must prevent* VAWH and they have obligations in that respect, as I will discuss further in chapter 3; they also are obliged to provide adequate health services. This argument is further supported by the acknowledgement that 'the act of abortion cannot be separated from the social conditions in which impregnation occurs and pregnancy is experienced,' and that laws on abortion should first consider 'matters like sexual aggression, inadequate or unavailable contraception, special legal controls on the conduct of pregnant women, and the patchwork of provisions … on maternity leaves, pregnancy discrimination and childcare.'[178]

Involuntary sterilisation

The IACHR, in *I.V. v. Bolivia*, defined informed consent as 'the positive decision to undergo a medical act, derived from a previous, free and informed decision or process,' characterised by 'an interaction between the doctor and the patient, through which the patient actively participates in the decision making process, moving away from the paternalistic approach of medicine and focusing on individual autonomy.'[179] It combined the individualistic view on autonomy with the more relational aspect of the interaction between the doctor and the patient.

As explored in chapter 1, involuntary sterilisation occurs when misleading information is provided to a woman in order to coerce her to undergo the procedure. The consent of the woman in these cases does not grant autonomy, the coerced consent resulting in a form of VAHW. I analysed several cases in chapter 1, such as the CEDAW Committee views in *Szijjarto v. Hungary,* decided in 2006. Andrea Szijjarto, belonging to a minority, was induced while in hospital to have her Fallopian tubes tied, and to sign a document the content of which she could not understand. The Committee clarified that, in cases of this kind, hospital personnel must inform the woman and provide information and counselling about sterilisation, as well as about alternatives. As I explained, these

cases are expressions of intersectional discrimination. The autonomy of a woman undergoing involuntary sterilisation is limited, not just because she is a woman, but also if she belongs to a specific minority, or is in one of several social or health conditions. Consent is not a genuine expression of autonomy in cases of involuntary sterilisation.

Obstetric violence and maternal health

As mentioned earlier, OV is a form of VAWH, and it is rarely recognised by laws and in courts, unless it leads to permanent and severe injuries or maternal death that call in question the responsibility of health personnel. Stereotypes interfere with the exercise of women's autonomy during pregnancy. Women's autonomy is impaired by decisions taken by others, or by health professionals, which affect reproductive freedom. The trend towards the 'medicalisation' of every process pertaining to women's reproductive rights is demonstrated by the state's male tendency to protect women even when this is not clinically necessary.[180] An example of non-consensual obstetric intervention, which amounts to VAWH, is forced caesarean section. Such interventions might be ordered by a court, with the aim of protecting the foetus, and against the woman's will.[181] Nonetheless, one could also reflect on the consent to vaginal delivery as the 'normal' and accepted form of delivery: should a woman be free to decide autonomously, informed of all possible consequences? Medicalisation does not only include forced interventions in the woman's body, but also tests and other technologies to which women consent. The 'normalisation of technology' in pregnancy is a concern for feminists, because it is not straightforward that the consent of the woman is 'sufficiently informed as to represent a genuine instance of informed choice.'[182] Normalising certain tests means that they are considered as a routine which is difficult to avoid, and even to question.

'Normalisation' also affects the place in which a woman gives birth to her child. The autonomy of the woman might indeed be limited when she cannot decide where to give birth, and is forced to choose a hospital over home birth. As Judge Tulkens pointed out in his opinion concurring with *Ternovszky*, decided by the ECtHR in 2010, in which a woman complained of not receiving adequate professional assistance during a home birth:

> Freedom may necessitate a positive regulatory environment which will produce the legal certainty providing the right to choose with effectiveness. Without such legal certainty there is fear and secrecy, and in the present context this may result in fatal consequences for mother and child.[183]

I argue that denying home birth might amount to a form of VAWH, especially when the woman prefers home birth in order to avoid a repetition of mistreatment or unconsented practices in hospitals that she experienced on a previous occasion. From a legal point of view, this is a violation of the woman's rights to health and to reproductive health, and her right to autonomously decide where to safely give birth to her child.

Access to contraception

Free and informed consent to contraception implies knowledge of the effects and side-effects of contraceptives pills. In particular, misleading information that EC is an abortifacient can impair a woman's decision, which should be autonomous and personal. Considerations related to this situation are similar to those I have already proposed for abortion and involuntary sterilisation.

A human-rights based autonomy: a new element for conceptualising VAWH?

I am borrowing the argument made by McLean to elaborate my own notion of autonomy, which helps the conceptualisation of VAWH. In her view, the language of human rights caused the relationship between doctor and patient to evolve during the twentieth century, and 'the rights that are central to every human rights declaration or treaty are essentially equivalent to respect for autonomy.'[184] As a consequence, the very idea of autonomy is inseparable from human dignity.[185] I would say that the very idea of autonomy is inseparable from the rights to health and to reproductive health. McLean also stressed how human rights are both individualistic and relational, therefore recognising that individual autonomy in the light of human rights law does not preclude consideration of the rights of groups and communities.[186] Autonomy permeates human rights law. The ECtHR refers to Article 8 ECHR (right to respect for private and family life) when dealing with cases of personal autonomy. For this reason, for example, in *Pretty v. United Kingdom*, the ECtHR brought the notion of personal autonomy within the scope of application of Article 8 ECHR, as an 'important principle underlying the interpretation of its guarantees.'[187] In *K.A. and A.D. v. Belgium*, the Court argued that the right to entertain sexual relationships comes from the right to dispose of one's body, which is *'partie intégrante'* of the notion of personal autonomy.[188]

A human rights-based autonomy contains both the dimensions we have discussed, namely the individual and the relational: the first, because it is the individual, as a human being, who has the right to make decisions about his/her own body, and the second, because the decision is taken in a context of relationships that inevitably affect it, even if we adhere to the purest model of individualism. A human rights-based autonomy is relevant when considering the legal instruments through which to realise the human rights to health and to reproductive health. For example, since no right to health is enshrined in the ECHR, the ECtHR referred to Article 8 as a legal pretext for discussing and protecting personal autonomy. Moreover, since free and informed consent is an expression of autonomy, then consent contributes to the realisation of this right.

In conceptualising the notion of VAWH, considering that the notion of autonomy is not part of the original definition of VAW, I argued that autonomy permeates both dimensions of the analysis. Common to both dimensions is the fact that a woman's autonomy diminishes when she is exposed to VAWH. It is also common that in both dimensions, the lack of consent – *rectius*, genuine

consent – causes the violation of the woman's rights. In that respect, I could add a further element to my definition of VAWH, namely the limitation of women's autonomy. VAWH is therefore a violation of human rights and a limitation of women's autonomy.

A human rights-based autonomy encompasses the principle of non-discrimination, and hence contributes to a process of 'gendering' autonomy, with the consequent analysis of whether, and if so, to what extent, limitations of women's autonomy derive from the fact of their being women. The legal consequences of this argument can be appreciated in different contexts. As for FGM/C, for example, I suggested that other practices that impair women's and girls' rights to health and to reproductive health, such as GCS, should be conceived as violations of human rights, unless genuine, informed consent of a woman older than 18 can be proved. This conceptualisation of VAHW, as read in conjunction with the analysis of the principle of autonomy, could well allow a reconsideration of the crime of FGM/C itself.

The notion of autonomy and consent will also be pivotal in criminalising OV, which few countries consider as an offence in their national penal code, but also in paving the way for the adoption of guidelines and recommendations for practitioners, which would constitute codes for conducting the activity of public hospitals. Considering a human rights-based autonomy also means considering a woman as holding human rights when deciding in matters related to her rights to health and to reproductive health (*mutatis mutandis* the reasoning on a human-rights based concept of autonomy can be extended to all genders). A state's policies on abortion must not cause, or contribute to causing, VAWH. Conscientious objection to abortion or to the provision of EC also represents the exercise of a right to self-determination, but is often abused, with the consequence that 'self-determination matters more or less depending whether it is exercised by the doctor or the woman.'[189] The thought of Francesca Rescigno precisely caught the point: a secular – truly secular – state (and for this scholar Italy is not) is a state in which the law does not interfere with self-determination, following the principles of equality and solidarity.[190] Society must be capable, in Rescigno's view, of adopting measures of prevention, education and assistance which affirm the 'freedom not to have an abortion,' and must 'step back before the woman's self-determination and will.'[191] Similarly, Rodríguez-Ruiz has contended that 'the choice of the woman must be autonomous,' and 'this includes the possibility of saying *No* to an unexpected pregnancy but also of saying *Yes* to it unimpeded by socio-economic constraints.'[192]

Conclusions

The concept: new elements and old ones

The diagnosis has allowed us to conceptualise the new concept of VAWH, which shares many elements with that of VAW, but at the same time better

encompasses the two dimensions of violence as conceived in this book. In particular, I followed the reasoning of the CEDAW Committee in its GR No. 35 when it contended that criminalising abortion, for example, is a form of VAW, and, more specifically, of gender-based violence against women. However, in state practice, and in the jurisprudence of human rights courts as well as in the quasi-jurisprudence of UN treaty bodies, VAW is generally conceived as interpersonal violence, or violence within the community, and it is harder to find clear affirmations of violence committed by the state through the adoption of laws and policies in the field of health. This is why the idea of VAWH can fill this gap. The concept of VAW can be complemented and enriched, but not replaced, by that of VAWH, to grasp the complexity of violence that derives from patterns of discrimination existing in society and in states' policies along a double dimension. VAWH is a form of discrimination against women, and a violation of their rights to health and to reproductive health, characterised by acts that produce physical and psychological harm. The element of intent is not relevant, much as it is not relevant in the definition of VAW; however, in both the horizontal and vertical dimensions it is possible to identify a 'pattern of discrimination,' which courts and UN treaty bodies have defined in different ways: as 'tolerance' to violence, but also in terms of 'repetition' of certain types of conduct. I also pointed out the importance of intersectionality in the analysis of 'patterns of discrimination,' which will prove to be helpful in theorising states' obligations, and in reflecting on reparations. Compared to the notion of VAW, I added to the notion of VAWH the element of consent, which expresses and gives strength to women's autonomy. VAWH is a limitation of women's autonomy and alters their consent.

Challenges to the public/private divide

My concept allows us to reflect on the 'public/private divide' developed, and challenged soon after its conceptualisation, by (Western) feminist scholarship. A product of the industrialisation process, this divide 'denotes the ideological division of life into apparently opposing spheres of public and private activities, and public and private responsibilities.'[193] The public/private distinction has also appeared in international law, where 'public' is the world of inter-state relations, whereas 'private' means national affairs.[194] Women have traditionally been excluded from international law and its legal structures.[195] The 'private', an author has argued, identifies what is 'free', 'the sphere in which others do not interfere,' while 'public' acquires 'a different meaning depending on the source of the interference.'[196] However, for women the 'private' sphere has been a zone of oppression, and of violation of their human rights.

Even though the distinction between public and private has been important when theorising and emphasising the unequal power relations between women and men, feminists have challenged it, considering it a myth. For example, Hilary Charlesworth, Christine Chinkin and Shelly Wright stressed 'the myth that State

power is not exercised in the "private realm" allocated to women masks its control.'[197] Others have pointed out that the sphere of the 'public' and the 'private' is too indeterminate.[198] And, indeed, the state has traditionally interfered in women's decisions about their sexuality and reproductive health, but refrained from intervening in the family context. Liberal states started to regulate reproduction during the late nineteenth and early twentieth centuries when industrialisation and universal suffrage 'began to transform *laissez-faire* State into mass (welfare) societies.'[199] The regulation of sex was deemed as essential in emergent welfare states. This was – and unfortunately seems to still be[200] – the product of a patriarchal understanding of society. Why are women's bodies always considered the *prime locus* of population control policies, and not men's? The answer is related to the stereotyped roles of the women in societies.[201]

In light of these views of the public/private divide, I can argue that women's rights to health and to reproductive health have been neglected because of the *male* conception of the private sphere. In this sense, the two approaches to the public/private divide, one in favour of it, the other more critical, can be reconciled to a certain extent. DV was a private matter in as much as reproductive decisions could not be left to the woman only. In both cases, women's autonomy was set aside.

The question is then to what extent must the state interfere in the private sphere? Gavison has proposed an interesting perspective. She said that what is 'private' can support claims both of non-interference – for example, in some decisions such as the timing and spacing of children – and of interference – for example, to fight against abuses – and that 'though we must assess such conflicting arguments to reach a conclusion, the fact that the same feature (privateness) may point in both directions does not undermine its utility.'[202]

After conceptualising the notion of VAWH, I can contend that the state must interfere in private life to the extent necessary to counter violence, without interfering with the exercise of women's autonomy in all instances related to their sexual and reproductive health. In other words, when we talk about violence and health, the state must interfere where there is an episode of violence that occurs within the community or within the family, but its intervention must stop when women's autonomy comes into play. To propose a clear example, rape must be prevented, and punished when it occurs, and it requires a clear intervention by the state both through laws and through specific actions ad hoc measured in relation to the situation of the victim. However, if the rape causes a pregnancy, then the state must refrain from interfering in whatever autonomous decision is taken by the woman relating to her reproductive health. Its intervention would in turn cause another form of violence against her health, perpetuating a patriarchal mechanism that the evolution of human rights law is progressively trying to dismantle. The state must intervene in cases of DV to protect the woman, and prosecute the perpetrator. In this example, it is clear how the divide is dismantled, and how DV comes into the public sphere. The protection of a woman who suffers violence, as Friedman has argued, 'comes with a price': loss of control over the legal

consequences that follow DV.[203] However, under my paradigm, the state must stop when its action causes VAWH in turn, for example in cases of secondary victimisation, provoking psychological violence. In that sense, the law should be 'more sensitive to the needs of crime victims.'[204] It is also possible to argue that states do not cause VAWH when they interfere with a woman's autonomy in ways 'required and justifiable to preserve individuals' human rights,' an example being the definition of a legal minimum age for marriage in order to save young women from the health risks of premature childbearing.[205]

To propose another example, to phase out OV the state – which acts through healthcare services and health personnel – must not interfere with a woman's free choice, and must always wait for her free and informed consent, unless it is a matter of urgency which leaves the practitioner no choice. Cases of OV analysed by national courts have proved to focus on malpractice rather than on the violation of the woman's human rights. This is not *per se* negative, because malpractice litigation can lead to a form of reparation for the suffering caused to the woman, but it does not take into account the violation of her rights to health and to reproductive health.

The example of FGM/C is more complex. The state must interfere to suppress this form of violence against girls' bodily integrity – irrespective, as I argued, of the 'intensity' of the harm, given the impact on physical and mental health – but must also pay attention to a woman's consent when she is capable of expressing her free consent without manipulation. I analysed this aspect in detail in 'Consent and autonomy in the horizontal dimension: FGM/C'. It was surprising to note that cases of FGM/C have mainly been decided at national level, especially in Europe and in the United States, rather than in front of regional human rights courts, and that they mainly concerned the recognition of refugee status of women escaping violence. This is less surprising when we consider the paternalistic attitude with which some courts have approached the problem, considering the girls and the women subjected to the practice as victims in need of protection from the 'brutality' of a traditional practice that comes from another 'culture'.[206] If I limit my analysis to FGM/C only, then my paradigm can be challenged, and sharply criticised because it is based only on a particular perspective of human rights which does not take into consideration cultural differences; however, if I develop my argument a bit further, as I did in 'Consent and autonomy in the horizontal dimension: FGM/C', and consider other practices, then the analysis is much more in line with my paradigm, and I can support my main argument on the presence of VAWH when consent to a practice, such as cosmetic genital surgery, is not free and genuine. I agree with the affirmation that 'culture is much more frequently invoked in the context of women's rights than in any other area,'[207] and that culture has been invoked in order to justify violations of women's rights. Here, indeed, I am not challenging this argument, but rather turning it into a reflection on women's autonomy and consent, considering that VAWH is a cultural phenomenon in every society. As Susan Deller Ross has argued:

> No ethical defense can be made for preserving a cultural practice that damages women's health and interferes with their sexuality. It is important, however, that those who are alien to the culture make themselves familiar with the causes and meanings of cultural practices and relate them to ideas of sex roles in their own societies.[208]

Victims/survivors and perpetrators

The notion of VAWH does not define a specific gender for the perpetrator. Men and women cause VAWH. Not prescribing a gender for the perpetrator does not diminish the understanding of VAWH as discrimination based on gender and characterised by unequal power relations between women and men. When a female obstetrician commits violence against women's health, she probably does not *intend* to commit violence. She might have experienced and internalised, or better, 'normalised,' the stereotype of the woman as mother, this way reproducing patterns of discrimination.

The woman who was subjected to a form of VAWH has been called, in the judgments and decisions I analysed in chapter 1, a victim, the applicant, the patient, occasionally the survivor, which is the language used (positively) in GR No. 35 adopted by the CEDAW Committee in 2017. From a legal perspective, one might argue that calling a woman 'survivor' instead of 'victim' does not change the substance of the complaint. Probably not, but it changes the lens through which the woman is seen during proceedings: not as a human being who cannot defend herself, always in need of help, but rather as an active agent of change.

Notes

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2 C.F. Kleisiaris, C. Sfakianakis and I.V. Papathanasiou, 'Health care practices in ancient Greece: the Hippocratic ideal', *Journal of Medical Ethics and the History of Medicine* 7 (2014) 6.
3 I. Scobbie, 'Thinking about international law', in Evans, *International Law*, p. 77, referring to C. Perelman and L. Olbrechts-Tyteca, *La nouvelle rhétorique: traité de l'argumentation* (Paris: University of Notre Dame Press, 1958).
4 Charles, 'Obstetricians and violence against women'.
5 See in that respect, S. De Vido, 'The prohibition of violence against women as customary international law? Remarks on the CEDAW General Recommendation No. 35', *Diritti umani diritto internazionale* 2 (2018) 379.
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7 J.S. Mill, *On Liberty* (1859) (Kitchener, Ontario: Batoche Books, 2001), p. 13.
8 J. Feinberg, *Harm to Others* (New York: Oxford University Press, 1984).

9 Eriksson, *Defining Rape*, p. 55.
10 Eriksson, *Defining Rape*, p. 67.
11 R. Rubio-Marín and C. Sandoval, 'Engendering the reparations jurisprudence of the Inter-American Court of Human Rights: the promise of the *Cotton Field* judgment', *Human Rights Quarterly* 33 (2011) 1062, p. 1068.
12 *Valiulienė*, para. 69.
13 Dissenting opinion of Judge Jõcienė, paras 11 and 12.
14 Sifris*, Reproductive Freedom*, p. 67.
15 Sifris*, Reproductive Freedom*, p. 67.
16 Sifris*, Reproductive Freedom*, pp. 77–8.
17 Eriksson, *Defining Rape*, p. 60.
18 See, for example, the Italian legislation until 1996 (chapter 1, 'Rape').
19 See, with specific regard to rape, R. Whisnant, 'Feminist perspectives on rape', in E.N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Fall 2017 edn), available at https://plato.stanford.edu/archives/fall2017/entries/feminism-rape/.
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21 Istanbul Convention, preamble.
22 Fredman, *Discrimination Law,* p. 41.
23 See, in that respect, CEDAW Convention, Article 5.
24 GC No. 20, ESCR Committee, para. 12.
25 *Da Penha*, paras 55 and 56.
26 *Gonzáles*, para. 170. C. Bettinger-Lopez, 'Introduction: *Jessica Lenahan (Gonzáles) v. United States of America*: Implementation, litigation, and mobilization strategies', *American University Journal of Gender, Social Policy, and Law* 21 (2012) 207.
27 *López Soto* (IACommHR), para. 224.
28 *López Soto* (IACHR), para. 223.
29 'Access to justice for women victims of sexual violence in Mesoamerica' (IACommHR), OEA/Ser.L/V/II. Doc. 63**,** 9 December 2011, para. 17.
30 *Opuz*, para. 192.
31 *Opuz*, para. 198. See P. Londono, 'Developing human rights principles in cases of gender-based violence: *Opuz v. Turkey* in the European Court of Human Rights', *Human Rights Law Review* 9 (2009) 657, p. 665.
32 *Talpis,* para. 145.
33 Judgment of 27 May 2014, Appl. No. 72964/10, *Rumor v. Italy.*
34 *Talpis*, paras 146–7. See also judgment of 28 May 2013, Appl. No. 3564/11, *Eremia and others v. Moldova* (ECtHR), paras 87 and 89.
35 Dissenting opinion of Judge Eicke, *Talpis*, para. 22.
36 This argument is presented in De Vido, 'States' due diligence obligations', and it is supported by a reference to the Istanbul Convention.
37 *González Carreño*, para. 7.5.
38 *Equality Now*, para. 125.
39 *CGIL v. Italy*, para. 190.
40 Sifris, *Reproductive Freedom*, p. 129. See also Greasley, *Arguments*, p. 88.
41 Sifris, *Reproductive Freedom*, pp. 130–1.

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43 Rubio-Marín and Möschel, 'Racial and gender-based violence', p. 193.
44 *I.G. and others*, para. 165.
45 CEDAW Committee, Concluding observations on Slovakia, CEDAW/C/SVK/CO/5–6, 25 November 2015, para. 32.
46 UN Committee on the Elimination of Racial Discrimination in Slovakia (CERD), Concluding observations on Slovakia, CERD/C/SVK/CO/11–12, 8 December 2017, para. 23.
47 CERD, Concluding observations, Slovakia.
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49 Sifris, *Reproductive Freedom*, p. 135.
50 S. Laurel Weldon, 'Intersectionality', in G. Goertz and A.G. Mazur (eds), *Politics, Gender, and Concepts* (Cambridge: Cambridge University Press, 2008) 193, p. 195.
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52 L.P.A. Sosa, *Intersectionality in the Human Rights Legal Framework on Violence Against Women* (Cambridge: Cambridge University Press, 2017), p. 15.
53 Sosa, *Intersectionality*, p. 16.
54 See the analysis of legal instruments in Sosa, *Intersectionality*.
55 Sosa, *Intersectionality*, p. 33, referring to the work by Margaret Satterthwaite, 'Women migrants' rights under international human rights law', *Feminist Review Labour Migrations: Women on the Move* 77 (2004) 167, p. 170.
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57 *Gonzáles*, para. 113.
58 See 'Consent and autonomy in the concept of VAWH' below.
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60 *CGIL v. Italy*, for example. For a comparative analysis (covering the United States, Europe, Latin America and South Africa) see A. O'Rourke, L. De Crespigny and A. Pyman, 'Abortion and conscientious objection: The new battleground', *Monash University Law Rev*iew 38 (2012) 87.
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63 CERD, Concluding observations, Slovakia, para. 23.
64 GR No. 35 (CEDAW), para. 12.
65 GR No. 35 (CEDAW), para. 9.
66 L. Peroni and A. Timmer, 'Gender stereotyping in domestic violence cases', in E. Brems and A. Timmer (eds), *Stereotypes and Human Rights Law* (Cambridge: Intersentia, 2016) 39, p. 45.
67 Explanatory report to the Istanbul Convention, para. 44.
68 Cook and Cusack, *Gender Stereotyping*, p. 9.
69 B. Bianchi, 'La violenza domestica nella riflessione femminista (1833–1917)', in S. De Vido and L. Candiotto (eds), *Home-Made Violence* (Milan: Mimesis, 2016) 17, p. 18.
70 Cook and Cusack, *Gender Stereotyping*, p. 36.
71 *A.T.*, para. 9.4. See Peroni and Timmer, 'Gender stereotyping', p. 43.
72 *Karen Tayag Vertido v. The Philippines*, Communication No. 18/2008, 16 July 2010 (CEDAW), para. 8.4. Emphasis added.

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74 *Vertido*, para. 8.4.
75 *Law and Advocacy for Women*, see chapter 1, note 236 and text to which it relates.
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77 S. Cusack, 'Building momentum towards change', in Brems and Timmer, *Stereotypes*, 11, p. 16.
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86 Hanna, 'Health, human rights', p. 146.
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89 Article 2, Inter-American Convention to Prevent and Punish Torture, 9 December 1985, Organization of American States Treaty Series No. 67.
90 *R.R.,* see chapter 1, notes 365 and 389 and related text.
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93 See, in more detail, De Vido, *Donne, Violenza*, p. 49.

94 Sheila Dauer has noted the existence of 'patterns of violence committed against women both by public and private actors ('Indivisible or invisible. Women's human rights in the public and private sphere', in Agosín, *Women, Gender, and Human Rights*, 66, pp. 79–80).
95 A comparative analysis of *mens rea* in different criminal law traditions and in international criminal law can be found in M. Elewa Badar, *The Concept of Mens Rea in International Criminal Law. The Case for a Unified Approach* (Oxford and Portland: Hart, 2013).
96 See Lord Goddard in *Brend v. Wood* [1946] 62 TLR 462 (Divisional court) at 463. Case reviewed in *Cambridge Law Journal*, 1947, p. 376*ff*.
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98 Copelon, 'Recognizing the egregious in everyday', p. 325.
99 Sifris, *Reproductive Freedom*, p. 106.
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104 *Opuz*, para. 191.
105 *Opuz*, para. 197.
106 See, for example, *Rumor*.
107 R. Pollack Petchensky, 'Abortion and women's choice: the state, sexuality and reproductive freedom', 1984, rev. 1990, republished in C. Grant, L.A. Rosenbury, D.T. Verkheimer and K.A. Yuracko, *Feminist Jurisprudence* (St Paul, MN: Thomson Reuters, 2011), p. 414.
108 M. Nowak and E. McArthur, *The United Nations Convention against Torture: A Commentary* (Oxford: Oxford University Press, 2008), p. 73. Reflecting on states legally restricting access to abortion and torture, see Sifris, *Reproductive Freedom,* p. 98. This problem echoes the doctrinal debate on negligence (*culpa*) in assessing international state responsibility, which started at the beginning of the twentieth century. See, without pretending to encompass a long and complex debate, the 'objective' conception of the act giving rise to international responsibility elaborated by Anzilotti, who argued against considering negligence as an element of an internationally wrongful act (D. Anzilotti, *Corso di diritto internazionale* (Rome: Atheneum, 1912–14), vol. I, pp. 251–2), and the position of scholars, such as Morelli, who have contended that state responsibility arises when state organs act with negligence, in particular in cases of due diligence obligations (G. Morelli, *Nozioni di diritto internazionale* (Padua: Cedam, 1967), p. 346).

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110 M. Friedman, *Autonomy, Gender, Politics* (Oxford: Oxford University Press, 2003), p. 3.
111 F. Rescigno, 'L'autodeterminazione della persona: il faticoso cammino del diritto positivo', *Rivista critica del diritto privato* 36 (2018) 13, p. 17.
112 GC No. 22, ESCR Committee, para. 25.
113 Nelson, *Law, Policy*, p. 2.
114 S.A.M. McLean, *Autonomy, Consent, and the Law* (Abingdon: Routledge, 2010), p. 6.
115 Friedman, *Autonomy, Gender, Politics*, p. 4.
116 See references in Nelson, *Law, Policy*. According to Sjöholm (*Gender-Sensitive Interpretation*, p. 517), procedural autonomy 'raises the question as to whether women can make autonomous decisions with regard to motherhood when they, as a group, are strongly socialised into motherhood,' whereas substantive autonomy is linked to ethics and reflects on 'which reproductive decisions should be considered to be human rights norms, such as whether it involves choosing the gender or physical appearance of the foetus, but also access to abortion or *in vitro* fertilisation.'
117 See McLean, *Autonomy, Consent*, pp. 13–14, referring to works by Kant, Mill and Kluge.
118 Friedman, *Autonomy, Gender, Politics*, p. 81.
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123 Sherwin, 'A relational approach', p. 36.
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126 Dodds, 'Choice and control', p. 226.
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129 Nelson, *Law, Policy*, p. 29.
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131 Nelson, *Law, Policy*, p. 31.
132 McLean, *Autonomy, Consent*, p. 41.

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134 McLean, *Autonomy, Consent*, p. 91.
135 Friedman, *Autonomy, Gender, Politics*, p. 141.
136 Friedman, *Autonomy, Gender, Politics*, p. 142*ff*. 'Why men rape' is one of the questions of feminist critique of rape law: is rape motivated by sex or power? The different views on the issue are reported in Grant *et al.*, *Feminist Jurisprudence*, p. 329*ff*.
137 Friedman, *Autonomy, Gender, Politics,* p. 147.
138 Friedman, *Autonomy, Gender, Politics*, p. 149.
139 See, in that respect, Article 49(2) of the Istanbul Convention: '[p]arties shall take the necessary legislative or other measures, in conformity with the fundamental principles of human rights and having regard to the gendered understanding of violence, to ensure the effective investigation and prosecution of offences established in accordance with this Convention.'
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148 The news was published in the *Guardian* in 2015. See https://www.theguardian.com/society/2015/feb/04/doctor-not-guilty-fgm-dhanuson-dharmasena.
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151 Phillips, *Gender and Culture,* p. 64.
152 See the website of the UK NHS, which stresses how the procedure differs from FGM: https://www.nhs.uk/conditions/cosmetic-treatments/labiaplasty/.
153 Except for intersex new-borns, who will be the subjects of future research. See, *inter alia,* the report by Human Rights Watch and InterAct, *I want to be like nature made me*, 2017.

154 See the declaration of a paediatrician, reported on 3 July 2017 on the BBC. The practitioner compared the surgery, where it is not necessary, to FGM: https://www.bbc.com/news/health-40410459. See also L. Avalos, 'Female genital mutilation and designer vaginas in Britain: crafting an effective legal and policy framework', *Vanderbilt Journal of Transnational Law* 48 (2015) 621, p. 694, referring to UK legislation, arguing that 'in keeping with the principle of nondiscrimination, GCS and FGM should be treated similarly under the law. This means that any non-medically necessary procedure carried out in contravention of the (UK) FGM Act should be prosecuted, regardless of whether the procedure is considered FGM or GCS by those involved.'
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161 Nelson, *Law, Policy*, p. 123.
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170 McLean, *Autonomy, Consent*, p. 152.
171 McLean, *Autonomy, Consent*, p. 153.
172 I. Karpin and R. Mykitiuk, 'Feminist legal theory as embodied justice', in Albertson Fineman, *Transcending the Boundaries of Law* 115, p. 119.
173 Rodríguez-Ruiz, 'Gender in constitutional discourses', p. 700.
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175 Laufer-Ukeles, 'The disembodied womb', p. 4.
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177 Greasley, *Arguments*, p. 199.
178 Martin, 'A woman-centered approach', p. 913.
179 *I.V.,* para. 166.
180 Laufer-Ukeles, 'Reproductive choice', p. 602.
181 See in that respect Nelson, *Law, Policy*, p. 186*ff*., and I.L. Feitshans, 'Legislating to preserve women's autonomy during pregnancy', *Medicine and Law* 14 (1995) 397, p. 404.
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189 Rescigno, 'L'autodeterminazione della persona', p. 26.
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