

Title: The Human Rights Impact of Gender Stereotyping in the Context of Reproductive Healthcare

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Synopsis:

This article highlights how, in the context of involuntary sterilization, ethical guidelines have been used to advance human rights standards on informed consent and on gender stereotyping in reproductive healthcare settings.

Key words: forced sterilization, stereotypes, human rights law, FIGO guidelines, Inter-American Court of Human Rights, informed consent, ethical standards

Abstract

Gender stereotypes about women's reproduction impede women's access to essential reproductive health care and contribute to women's inequality more generally. Stereotyping in health care settings impedes women's access to contraceptive information and services and abortion, and lead to involuntary interventions in the context of sterilization. Decisions by human rights treaty monitoring bodies, such as the Inter-American Court of Human Rights' case, *IV v. Bolivia*, which was a case concerned with the involuntary sterilization of a woman during childbirth, highlight how stereotypes in the context of providing health care can operate to strip women of their agency and decision-making authority, deny them their right to informed consent, reinforce gender hierarchies and violate their reproductive rights. *IV v Bolivia* is examined as a case study with the objective being to highlight how, the context of coercive sterilization, human rights law has been used to advance legal and ethical guidelines, including FIGO's own guidelines, on gender stereotyping and reproductive healthcare. The Inter-American Court's judgment in *I.V. v Bolivia* illustrates the important role FIGO's guidance can play in shaping human rights standards and provides guidance on the service provider's role and responsibility in eliminating gender stereotypes and upholding and fulfilling human rights.

Introduction

Women and persons who do not conform to traditional gender identities, such as transgender persons for example, face pervasive and persistent harmful gender stereotypes in the exercise of their sexual and reproductive rights, including in the receipt of health care services [1]. Stereotypes exist because of strong religious, social and cultural beliefs and ideas about sexuality, pregnancy and motherhood. They are social and cultural constructions of men and women based on their different physical, biological, sexual and social functions. Gender stereotyping is the practice of ascribing these attributes to individuals, which poses a significant challenge to the practical realization of human rights. Gender stereotypes are often formed to exert control over women or persons not conforming to traditional gender norms. They are both a root cause and consequence of discrimination and a contributing factor to a broad range of human rights violations, including in the health care context [2].

The International Federation of Gynecology and Obstetrics recognized this challenge and issued an ethical guideline to OBGYNs on identifying and avoiding stereotyping of both patients and colleagues. The guideline, *Harmful Stereotyping of Women in Health Care*, explains:

Stereotyping of others is a common phenomenon of human perception. Stereotypes provide an initial sense of people we do not know, and serve to place them within a framework familiar to ourselves. The harm of stereotyping occurs when health care providers simply apply stereotypes without acquiring knowledge of their patients' or colleagues' true characteristics, wishes and intentions, or without showing respect for their particular individuality [1].

The guideline further recognizes the prevalence of gender stereotyping in reproductive health care: “(s)tereotypical thinking about women, their roles in society and in their families, their capacities and preferences, has permeated health care in general, and reproductive health care in particular.” Human rights treaty monitoring bodies, such as the United Nations’ Committee on the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), recognize that stereotyping in the reproductive health care context is not uncommon and can cause harm to women’s individual, physical and mental well-being [3]. Human rights and medical ethical standards on stereotyping are relevant in hospital and court rooms alike. The Inter-American Court of Human Rights, which is the human rights court tasked with monitoring state compliance with regional human rights treaties in the Americas, recently issued judgment in the case, *IV v. Bolivia*, and significantly brought together FIGO standards and human rights principles on stereotyping to ensure the responsibility of health care providers to acquire informed consent and to protect against the involuntary sterilization of women. Whereas human rights discourse is not often applied in the medical context, and *vice versa*, this case illustrates the benefit and utility of cross-pollinating human rights law and medical ethics standards. Such engagement has the potential to provide comprehensive guidance in eliminating stereotyping in reproductive healthcare contexts [4].

This paper introduces the human rights and ethical standards on stereotyping and consent in the context of involuntary sterilization, and it employs a human rights law case study to highlight how reproductive health care providers are required to comply with ethical and human rights standards in their provision of care. The first section provides an overview of the impact of stereotyping in the health care sector, with a particular focus

on how stereotyping contributes to violations of patients' rights to informed consent and can result in the involuntary sterilization of women. The second section analyzes *IV v. Bolivia* with the objective of extrapolating lessons relevant to service providers as they are required to refrain from gender stereotyping. The second section concludes with a series of recommendations intended to assist service providers in eradicating stereotypes as they provide reproductive health care for women. The *IV v. Bolivia* judgment is groundbreaking in highlighting the paramount importance of rejecting stereotypes as part of the informed consent process in the arena of reproductive health care and in its use of FIGO guidance to articulate this as a violation of human rights.

1. Stereotypes in Relation to Reproduction and Consent

One of the pervasive stereotypes is that because women are considered vulnerable and emotionally volatile, they are incapable of making rational decisions about their reproductive capacity. Women are thus perceived as individuals in need of being controlled and incapable of exercising their agency, and should therefore “be denied access to health care services of their choice” [5]. Accordingly, the stereotype maintains that men and people in positions of authority, such as doctors who perform medical procedures, male family members, or society at large, are better positioned to make decisions for women. This stereotype operates to deny women information to make informed decisions about their reproductive health and substitutes the decisions of others for their own. Moreover, these stereotypes are compounded by other characteristics, such as age, HIV status, race, ethnicity, and disability, sexual orientation or gender identity or expression, which make women particularly vulnerable to abuses in this context.

Stereotypes that depict individuals who deviate from traditional gender roles as abnormal work to deprive these groups of autonomy in decision-making in the health care context. Further compounding these stereotypes are hierarchies in the health care field between health care providers who hold medical knowledge and patients who are dependent on the health system to obtain information and care. In these settings, health care providers may seek to advance sex-specific norms based on their personal, religious or cultural beliefs in the context of providing care. As such, rather than provide treatment in accordance with the needs and desires of the patient, health care providers may rely on gender stereotypes to exploit their authority and deny patients access to services or subject them to certain medical treatments [5]. For example, health care providers may influence women to continue a pregnancy, cease reproduction, or fail to inform them of available alternative treatments, and withhold information necessary to ensure a woman's informed consent to a procedure [1, 5, 6].

1.1 FIGO Guidance

To address this challenge the International Federation of Gynecology and Obstetrics issued an ethical guideline, *Harmful Stereotyping of Women in Health Care*, which recognizes harmful stereotyping of women in the provision of health care and providing guidance to OBGYNs on identifying and avoiding stereotyping of both patients and colleagues. The guideline identifies some specific stereotypes that can lead to conduct which contravenes both ethical and human rights standards, namely that women “are vulnerable and incapable of reliable or consistent decision-making” and “that they will be subordinate to men such as fathers, husbands, brothers, co-employees and doctors.” The

guidelines also recognize harms resulting from such stereotypes, including coercive practices during childbirth and sterilization [1]. (The FIGO guidelines on *Female Contraceptive Sterilization*, which include important guidance on informed consent, were issued the same year as the FIGO guidelines on avoiding stereotypes [7].

FIGO's recommendations addressing these challenges mandate that health care providers should not limit or bar women's access to health services, which includes inequitable quality of care due to negative female characterizations. Hence, they should be aware of, resist, and redress, their own and others' tendencies to consider women through stereotypes, such as those that assume women are emotional, vulnerable, or lacking sound moral judgment. Providers should instead promote women's dignity and rights to pursue self-fulfillment equally with that of men. The FIGO recommendations also place a responsibility on health care providers to be "equally proactive to identify and redress any tendencies of their colleagues, their health care institutions and their professional organizations to approach women through similarly demeaning stereotypes, and teach by instruction and example the promotion of women's equal dignity and rights." [1]

In the context of informed consent for sterilization, a World Health Organization inter-agency statement on sterilization provides guidance to states on how best to ensure informed consent in the provision of sterilization services, and highlights certain groups of women who are particularly vulnerable to involuntary sterilization due to gender stereotypes [8].

1.2 Human Rights Standards on Eliminating Gender Stereotypes

Not only have medical associations and bodies, such as FIGO and WHO addressed the problems of gender stereotyping in health care contexts, but numerous United Nations (UN) and regional human rights bodies recognize this problem in the health care field and have articulated the harm resulting from stereotyping as a violation of human rights. The CEDAW Committee, which monitors state compliance with CEDAW, is at the forefront of addressing gender stereotypes [1]. In the context of health care, the CEDAW Committee recognized that “gender stereotypes may impact women’s capacity to make free and informed decisions and choices about their health care, sexuality and reproduction and, in turn, also impact on their autonomy to determine their own roles in society.” [4] The UN Special Rapporteur on Health recognized the doctor-patient power dynamic, noting that states must protect the right to autonomy over medical decisions as a counterweight to “the imbalance of power, experience and trust inherently present in the doctor-patient relationship.” [9] The African Commission on Human and Peoples’ Rights noted that efforts to eliminate gender stereotyping “be especially made to address patriarchal attitudes, as well as the prejudices of health care provider [...]” [10]. Numerous other expert human rights bodies recognize the vulnerability of women in health care contexts, urging states to prevent coercion in regards to fertility and reproduction [11].

While gender stereotypes about women’s reproduction impede their access to contraceptive information, services and abortion, such stereotypes also lead to involuntary interventions in the context of sterilization. The UN Special Rapporteur on Torture noted the paternalistic assumptions underlying this practice: “the administration

of non-consensual medication or involuntary sterilization is often claimed as being a necessary treatment for the so-called best interest of the person concerned.” [12]. He referenced the International Federation of Gynecology and Obstetrics ethical guidelines on sterilization, which note,

(S)terilization for the prevention of future pregnancy cannot be ethically justified on grounds of medical emergency. Even if a future pregnancy may endanger a woman’s life or health, she must be given the time she needs to consider her choice. Her informed decision must be respected, even if it is considered liable to be harmful to her health. [12].

The issue of informed consent and sterilization has been addressed routinely by the World Health Organization and by international, regional and national courts, which have found such practices in violation of numerous human rights, including the right to be free from discrimination and from inhuman and degrading treatment, the right to private life, and the right to health [8]. They have called on states to ensure proper laws and guidelines are in place to guarantee informed consent, provide redress when harm has occurred and to address gender stereotyping which leads to such violations. Additionally, they recognize that women and girls from marginalized groups, including, Roma women, women living with HIV, migrant women, poor women, women with disabilities and transgender persons, are particularly vulnerable [8,10, 13, 14, 15, 16].

The Inter-American Court’s 2016 case on involuntary sterilization, *IV v. Bolivia*, provides groundbreaking authority on human rights law interpretations of how stereotyping impacts women’s access to their reproductive health care rights. [17]

2. *IV v. Bolivia*: Involuntary Sterilization and Gender Stereotyping

The Inter-American Court of Human Rights recently issued judgment in its second reproductive rights case, *I.V. v. Bolivia*, representing the first time the Court examined involuntary sterilization. The case is significant for its analysis of the impact of gender stereotyping on women's access to reproductive healthcare. In this brief case study, we introduce the Court's key findings and arguments in regards to stereotyping and involuntary sterilization. The objective of the case study is to highlight how human rights law may be used to advance legal and ethical guidelines, including FIGO guidelines, on gender stereotyping and reproductive healthcare, and to establish standards for physicians when providing reproductive healthcare services.

2.1 Case Overview

In July 2000, IV, a poor Peruvian woman, mother of three, and refugee, underwent a caesarian procedure in La Paz, Bolivia [18]. During the procedure, the surgeon performed a fallopian tube ligation. IV was told the day after the procedure that she had been sterilized. However, when she asked if her life or if the life of her baby had been at risk and therefore warranted the procedure, she was informed the procedure was carried out because a future pregnancy would be potentially dangerous. IV stated she had not consented to such a medical intervention, yet the surgeon maintained he received verbal authorization during the procedure. IV raised charges against the physician before three criminal courts spanning six years, until finally a Bolivian criminal court dropped the case [18]. Shortly after, IV brought her case to the Inter-American Commission on Human Rights, which then referred the case to the Inter-American Court on Human Rights in April 2015 [19]. In alleging charges, IV argued in part that the Bolivian government failed to

provide effective standards on informed consent and gender stereotyping, and did not maintain effective mechanisms for state oversight and supervision of health institutions.

During the proceedings of this case before the Inter-American Court, expert witnesses provided testimony before the Court and lawyers and activists submitted briefs (*amicus curiae*), including about the impact of stereotyping on reproductive healthcare [20, 21]. The Court issued judgment in November 2016, where it determined that the Bolivian State had failed to protect IV's human rights [17]. It concluded that the involuntary sterilization of IV violated human rights protections such as the rights not to be subjected to torture or to cruel, inhuman, or degrading punishment or treatment; the right to personal liberty and security; the right to judicial protection; the right to privacy, which includes the right to dignity and the right to private life; the right to information; the right to found a family; and the rights of women to be free from violence and discrimination. [22, 23] This wide breadth of rights violations, as determined by the Inter-American Court of Human Rights, provided an ample framework to develop an analysis of involuntary sterilization as a form of torture, as a violation of the right to information, and as a women's rights violation. However, of particular relevance to this paper is the Inter-American Court's analysis of how gender stereotyping played a role in the violation of IV's human rights.

The Court suggested several ways in which gender stereotypes apply to women when engaging with the health sector:

- (i) women are identified as vulnerable and unable to make reliable or consistent decisions; which means that health professionals deny them necessary information;

- (ii) women are considered impulsive and voluble beings, so they require management by a more stable-minded person, usually a protective man; and
- (iii) women must be responsible for the sexual health of the couple, so that it is the woman in a relationship who has the task of choosing and using a contraceptive method.

The Court determined that while both men and women may undergo (consensual) sterilization procedures, “non-consensual sterilizations disproportionately affect women exclusively because they are socially assigned to the reproductive and family planning functions.” [17] To further unpack how gender stereotypes impact women’s access to reproductive health care, the Court analyzed the following themes: (i) the compound/ intersectional nature of stereotyping and its impact on involuntary sterilization; (ii) the unequal power dynamic between physician and patient (paternalistic control); (ii) the inherent link between gender stereotyping and informed consent; and (iv) the indivisible connection between women’s rights and involuntary sterilization. These intersecting themes are explored below in more detail and serve as the foundation for recommendations outlined in this section.

2.1.1 Intersectional Discrimination and Involuntary Sterilization

In considering the impact of stereotyping on involuntary sterilization, the Inter-American Court took into account IV’s multiple identifying characteristics as they were grounds for discrimination on the part of the healthcare providers. The Court recognized

certain groups of women suffer discrimination throughout their lives based on more than one factor combined with their sex, increasing their risk of violence and other human rights violations. [...] (S)terilization without consent is a phenomenon that has had a greater impact on women, in various contexts and parts of the world,

who are part of groups that are more vulnerable to human rights violations based on their socio-economic position, race, disability or HIV status [17].

Ultimately, the Court contended, “the discrimination experienced by IV in accessing justice was not only caused by multiple factors but resulted in a specific form of discrimination based on the intersection of those factors, that is, if any of these factors had not existed, discrimination would have had a different nature.” The Court referred to the FIGO guidelines on sterilization to determine, “(f)actors such as race, disability, and socio-economic position cannot be the basis to limit the free choice of a patient in regards to sterilization, nor to prevent obtaining their consent.” [17]. This analysis of intersectional discrimination contributed to the Court’s determination that the Bolivian State failed to fulfill the human rights obligation to prevent situations of discrimination against women.

2.1.2 Power and Paternalistic Control

The Court examined power dynamics and paternalistic control in the healthcare sector through its analysis of informed consent and state responsibility to prevent discrimination. Referring to FIGO guidelines on harmful stereotyping, the Court recognized the “unequal power relations historically characterized (between) men and women” and the impact of this power imbalance as it applies to the physician-patient relationship. The Court explained that in the context of reproductive healthcare, “the special relationship between the doctor and the patient becomes relevant.” Not only is the relationship “characterized by the asymmetry in the exercise of power that the physician assumes due to their specialized knowledge and the control of information they maintain,” but this power relationship (paternalistic control), also requires health care providers to uphold certain

medical ethics, principally “patient autonomy, beneficence, non-maleficence and justice.” The Court concluded that “the differences in relations of power, with respect to the husband, the family, the community and medical personnel” (had) an impact on how IV, and women generally, access reproductive healthcare. Furthermore, the Court drew a connection between paternalistic control and vulnerability factors aside from gender which compound the nature of control, such as race, disability, and socioeconomic position. The Court ultimately determined that health care providers have an obligation to empower and collaborate with patients, while simultaneously ensuring their own personal, religious and cultural beliefs do not influence the medical care they provide. [17].

2.1.3 Stereotyping and Informed Consent

Alongside the Court’s analysis of power and control as they relate to the health sector, the Court examined how gender stereotyping impacts the right to informed consent. The Court relied on informed consent standards set by international bodies such as FIGO and the WHO to determine “health services provided to women will be acceptable only if their consent is guaranteed prior with full knowledge of the cause, that is, if the consent is prior to the medical intervention.” [17]. Notably the Court contended that consent given during a surgical procedure does not constitute informed consent. In addition, it established a link between informed consent and gender stereotyping by asserting that “negative or harmful gender stereotypes can impact and affect access to women’s sexual and reproductive health information, as well as the process and manner in which consent is obtained.” The Court concluded that because the service providers involved in the sterilization of IV did not obtain informed consent, and because the Bolivian State’s

regulatory preventive measures were not sufficient to establish clear medical obligations to obtain consent, the State violated IV's human rights. The Court asserted that the failure on the part of the medical doctor to obtain IV's informed consent was a violation of her human rights, including her rights to information and dignity [17].

2.1.4 Women's Rights and Involuntary Sterilization

The *IV v. Bolivia* case represents the first time the Inter-American Court of Human Rights examined women's reproductive health through the region's violence against women human rights treaty, the Convention of Belém do Pará [23]. In analyzing violations of the Convention of Belém do Pará, the Court stressed

the seriousness of this violation as a violation of women's rights because it is necessary to make visible practices such as those verified in this case that may obscure negative or harmful gender stereotypes associated with healthcare services and lead to legitimize, normalize or perpetuate non-consensual sterilizations that disproportionately affect women.

The Convention of Belém do Para requires that states, and indeed health care providers, do more than simply refrain from violating reproductive rights, they must take action to uphold and enact these rights [17]. The Convention includes discrimination against women in its definition of violence against women, and mandates that states take all necessary measures to *prevent* violence against women. In the context of medical healthcare, this means states must develop strategies to eradicate stereotypes, as well as operate effective guidelines and compliance monitoring mechanisms on informed consent. Health care providers, for their part, have an obligation to understand the

inherent connection between women's rights and medical care. That is, the stereotyping of women in the reproductive health arena should be interpreted as a form of violence against women.

2.2 Recommendations

The *IV v. Bolivia* judgment concludes with a series of orders that the Bolivian State is required to implement in order to prevent future violations of women's reproductive rights. Alongside requiring the State to create and disseminate a booklet outlining patient's rights and the legal framework on informed consent, the Inter-American Court ordered the Bolivian State to "adopt permanent education and training programs aimed at medical students and medical professionals [...] on issues of informed consent, gender-based discrimination and stereotypes, and gender violence." [17]. This remedy takes into consideration the critical role service providers have in ensuring the protection and fulfillment of reproductive health rights. While certainly training and education programs geared towards medical students and professionals in gender stereotyping, informed consent and gender-based violence are an imperative, it is essential that such programs address the impact of intersectional discrimination and asymmetrical power imbalances between patients and their service providers as these often result in violations of human rights. The training itself should be developed with government, academic and civil society oversight to ensure it is effective and comprehensive.

Additionally, in local and national contexts where the guidelines and standards on informed consent are nonexistent or ineffectual, service providers have an obligation to

become familiar with and apply international standards. These standards should include ethical guidelines, such as those developed by FIGO, and human rights standards.

Finally, service providers have a responsibility to examine their own implicit and explicit bias when providing reproductive health care. While governments have a duty and a human rights obligation to monitor and provide oversight to ensure service providers provide equitable care, it is also the provider who must take care to unpack how their own bias can be used to impose harmful stereotypes.

Conclusion

Stereotypes operate to ignore women's abilities, needs, characteristics, wishes, and circumstances in ways that strip them of their agency and individuality, deny them their reproductive rights, and reinforce gender hierarchies [24]. Such stereotypes impede women's access to essential reproductive health care and contribute to women's inequality more generally [2]. *The IV v. Bolivia* case is groundbreaking in highlighting how gender stereotypes impact women seeking reproductive healthcare and in its use of FIGO guidance to articulate this as a violation of human rights. While international law condemns states when they fail to protect, promote and fulfill human rights, service providers have an obligation to adopt a human rights-based approach when providing healthcare services, in line with FIGO guidance, which requires a complete rejection of stereotypes based on gender, and other intersectional determining characteristics, including race, ethnicity, citizenship status, disability, HIV status, sexual orientation and/or gender identity.

Health care service providers working in the arena of reproductive health care have an obligation to consider not only the medical ethical considerations inherent to their work, but also human rights law standards relevant to reproductive rights. The above analysis of *IV v. Bolivia*, and subsequent recommendations, are intended to provide health care practitioners with a human rights-based perspective for eliminating gender stereotyping in their provision of care.

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