Committee on the Elimination of Discrimination Against Women (CEDAW)
Human Rights Council and Treaty Mechanisms Division
Office of the United Nations High Commissioner for Human Rights
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Submission to the Committee on the Elimination of Discrimination Against Women

1. Introduction

The Center for Health and Human Rights of the O'Neill Institute for National and Global Health Law at Georgetown University Law Center and the Ríos-Rivers organization, respectfully submit the following contributions for *General Recommendation No. 41 on the impact of gender stereotypes on the enjoyment of the rights enshrined in the Convention* for consideration by the United Nations Committee on the Elimination of Discrimination Against Women (CEDAW).

The O'Neill Institute is a non-profit institution located at Georgetown University in Washington, D.C. Its mission is to conduct rigorous research to identify solutions to pressing national and international health concerns. The Center for Health and Human Rights, one of the areas of work within the O'Neill Institute, works to improve health through academic research that focuses on the intersection of health and national and international human rights law. A key facet of our work involves engagement in domestic and international standard-setting processes to advance health, justice, and equity in all of its dimensions through the strategic use of human rights legal frameworks.

Ríos is a nonprofit organization based in Washington DC that provides strategic support to local and regional organizations in Latin America and the Caribbean that work on reproductive and social justice through strategic lawyering and technical legal work. Ríos-Rivers works closely with the O'Neill Institute's Health and Human Rights Initiative in the provision of technical assistance to local partners.

Given these backgrounds and acknowledging the considerable significance of CEDAW's General Recommendations in interpreting international human rights law, we find it relevant to highlight specific topics that, we hope, will contribute to the Committee's efforts to draw attention to the different ways in which gender stereotypes can undermine the enjoyment of the right to health.

Our submission is structured as follows. First, we examine how gender stereotypes restrict autonomy, limit access to healthcare services, and impact the quality of care received by women and girls. We then explore the influence of gender stereotypes on sexual and reproductive healthcare, highlighting their disproportionate adverse impact on specific groups of women. Finally, we present a list of recommendations that the General Recommendation can formulate to State parties.

2. Gender stereotypes and women's and girls' health

Gender stereotypes have been understood as the social and cultural construction of men and women, shaped by their differing physical, biological, sexual, and social roles.[1] These stereotypes are often the root cause of discrimination faced by women and girls, impacting various aspects of their lives, including their health.[2]

As a determinant of health, gender stereotypes shape societal norms, roles, and power dynamics, that influence vulnerabilities to illness, health behaviors, and access to healthcare in general.[3] Under article 12 of CEDAW, states must take all appropriate measures to eliminate discrimination against women in the field of healthcare.[4] However, gender stereotypes create significant barriers to meeting this obligation by restricting autonomy, limiting access to health services and affecting the quality of care that women and girls receive. Various sources have identified the detrimental impacts of these stereotypes on the health of women and girls. Throughout this submission, our objective is to highlight how these dynamics affect different dimensions of health in an interconnected way, including prevention, diagnosis, treatment, and autonomy. We consider it is essential that the Committee therefore recognizes and addresses the impact of these stereotypes on the health of women and girls, ensuring an approach that encompasses all these dimensions and promotes concrete actions for its eradication.

Gender stereotypes reinforce health inequities. According to the World Health Organization's Equity Framework, equity requires the absence of unfair, avoidable, or remediable differences among groups, whether defined by social, economic, demographic, geographic, or other dimensions of inequality. Health equity is achieved when everyone has the opportunity to reach their full potential for health and well-being. However, as the WHO highlights, discrimination, stereotyping, and prejudice, based on sex, gender, age, race, ethnicity, or disability, among other factors, exacerbate inequities by worsening living conditions.[5]

Other UN Treaty Bodies and mandates have also acknowledged their harmful impact on health. As such, the Committee on Economic, Social and Cultural Rights has recognized that stereotyping can affect access to other health determinants, such as water and food.[6] Similarly, the Committee on the Rights of the Child has stated that these beliefs and practices can negatively affect girls' health and overall development.[7]

Moreover, in its thematic report on eliminating discrimination against women regarding health and safety, the Working Group on Discrimination Against Women and Girls highlighted that women's bodies are

[1] Rebecca J. Cook & Simone Cusack, Understanding Gender Stereotyping, in Gender Stereotyping 9 (2010), https://www.jstor.org/stable/j.ctt3fhmhd.
[2] *See*, e.g., Committee on the Elimination of Discrimination Against Women, R.K.B. v Turkey. Communication No 28/2010 (2012). UN Doc. CEDAW/C/51/D/28/2010. Para. 8.8.; Committee on the Elimination of Discrimination Against Women, S.T. v Russian Federation (2019). Communication No 65/2014 (2019) UN Doc. CEDAW/C/72/D/65/2014. Para .9.; Committee on the Elimination of Discrimination Against Women, L.C. c/ Perú, Communication No. 22/2009 (2011). UN Doc. CEDAW/C/50/D/22/2009.

[3] World Health Organization, "Gender and health", https://www.who.int/news-room/questions-and-answers/item/gender-and-health.
[4] Convention on the Elimination of All Forms of Discrimination Against Women, Art. 12. Dec. 18, 1979, 1249 U.N.T.S. 13.
[5] *See*, World Health Organization, "Health Equity", https://www.who.int/health-topics/health-equity.
[6] Committee on Economic Social and Cultural Rights, General Comment No. 16: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights (2005). UN Doc. E/C.12/2005/4. Para. 29.
[7] Committee on the Rights of the Child, General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24) (2013). UN Doc. CRC/C/GC/15. Para. 9.

instrumentalized for cultural, political, and economic purposes rooted in patriarchal traditions. This instrumentalization, both within and beyond the health sector, serves to perpetuate taboos and stigmas related to women's bodies, sexuality, and reproductive roles. As a result, women face systemic barriers to accessing healthcare and maintaining autonomous control over their own bodies and medical decision-making.[8]

Stereotypes heavily impact on the quality of care of women and girls. Studies have shown that stereotypes permeate the healthcare system, affecting patients, researchers, and clinicians alike. This contributes to gender bias in medical treatment, often manifesting as medically unmotivated differences in the diagnosis, treatment, and care of men and women. [9]

One of the most documented forms of gender bias in the healthcare sector has been a tendency to dismiss women's symptoms. In recent years, increasing evidence has highlighted this issue, revealing that women's pain and symptoms are more frequently attributed to emotional or psychological causes rather than physical or biological ones.[10] Differences in treatment have been found in several medical fields including heart disease, polypharmacy, chorionic pain, within others.[11]

Negative gender stereotypes such as the objectification of women and the stigmatization of their health also affect women and girls. Objectification was highlighted as a pervasive issue, with the Working Group noting that women's bodies are frequently instrumentalized as objects for sexual or other purposes. This includes harmful practices like invasive cosmetic procedures and the promotion of unhealthy weight-loss diets, particularly among adolescent girls. These practices often lead to severe health consequences, including eating disorders such as anorexia and bulimia.[12] Stigmatization of women's health was also critically addressed. The report emphasized that harmful gender stereotypes and taboos continue to surround natural biological functions, such as menstruation, breastfeeding, and menopause. Additionally, the diagnosis of mental illnesses in women is often biased in ways that reinforce stigma. In some cases, these biased diagnoses have been used to unjustly institutionalize women against their will.[13]

Modernization and the use of technology in healthcare can amplified these issues. Studies have shown that biases that exist in society influence the clinical data used to develop algorithms and artificial intelligence. In turn, these biased algorithms shape clinical decisions, reinforcing existing inequalities. This creates a vicious cycle where gender inequality continues to be embedded in healthcare practices.[14]

2.1. Stereotypes in sexual and reproductive healthcare

[8] UN Working Group on the issue of discrimination against women, Report of the Working Group on the issue of discrimination against women in law and in practice (2016). UN Doc. A/HRC/32/44. Para. 18.
[9] Samulowitz, A. et al., *"Brave Men" and "Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain*, 2018, p. 2. PAIN RESEARCH & MANAGEMENT: THE JOURNAL OF THE CANADIAN PAIN SOCIETY (2018).; N. Krieger, "Genders, sexes, and health: what are the connections—and why does it matter?," International Journal of Epidemiology, vol. 32, no. 4, pp. 652–657, 2003.
[10] Samulowitz, *supra note* 9.
[11] *Id.,* 8.
[12] Report of the Working Group on the issue of discrimination against women in law and in practice (2016). UN Doc. A/HRC/32/44. Paras. 65 - 66.
[13] *Id.,* para. 67.
[14] Anagha Joshi, *Big Data and AI for Gender Equality in Health: Bias Is a Big Challenge*, 7 FRONT BIG DATA 1436019 (2024).

Gender stereotypes deeply influence various aspects of healthcare, but their impacts are particularly pronounced in the area of sexual and reproductive health.[15] These stereotypes create significant barriers to accessing essential reproductive health services, such as contraception and abortion, while also restricting women's autonomy in decision-making. In many cases, they lead to coercive practices, including forced sterilizations and the denial of necessary medical interventions. As this Committee has recognized, *"gender stereotypes can affect a woman's ability to make free and informed decisions about her medical care, sexuality, and reproduction, and they also impact her autonomy to determine her own role in society."*[16]

One of the core beliefs of these stereotypes is the idea that a woman's primary role in society is reproduction and motherhood. Rooted in cultural, religious, and social norms, this notion has led to the idea that women should carry pregnancies to term at all costs, even when doing so threatens their health and lives.[17] This harmful perception was central to L.C. v. Peru, where a young girl was denied timely spinal surgery due to the assumption that her reproductive capacity was more important than her fundamental rights.[18] Similarly, in Mellet v. Ireland, the Human Rights Committee concluded that criminalizing abortion reinforces gender-based stereotypes by framing women's primary role as that of mothers, thereby subjecting them to discrimination.[19] Further, in the Camila v. Peru case, the Committee on the Rights of the Child determined that the "lack of access to safe abortion and her subsequent prosecution for self-abortion constituted in themselves differential treatment based on the author's gender, as she was denied access to a service that was essential for her health and was punished for not complying with gender-based stereotypes relating to her reproductive role."[20]

Stereotypes have also impacted on women's access to contraceptive methods. This is driven both by the idea that women's primary role in society is to be mothers, and the belief that single women should remain chaste.[21] As a result, unmarried women and adolescent girls are often denied access to contraceptive information and services under the assumption that such access would encourage promiscuity.[22] This discriminatory practice infringes upon their right to health services, information, and the ability to decide the number and spacing of their children.[23]

Other frequent beliefs include the idea that they are vulnerable and incapable of reliable or consistent decision-making and that they will be subordinate to men.[24] Following this belief, some countries have enacted discriminatory laws or practices that include spousal or third-party consent for women's medical

[15] FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health. Harmful stereotyping of womenin healthcare (2011). In: Ethical Issues in obstetrics and gynecology. London: International Federation of Gynecology and Obstetrics; 2012:28–32

[16] Committee on the Elimination of Discrimination Against Women, Summary of the inquiry concerning the Philippines under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (2015). UN Doc. CEDAW/C/OP.8/PHL/. Para. 42.

[17]Office of the High Commissioner, Background paper on the role of the judiciary in addressing the harmful gender stereotypes related to sexual and reproductive health and rights (2017) p. 6. https://www.ohchr.org/sites/default/files/JudiciaryRoleCounterStereotypes_EN.pdf

[18] Committee on the Elimination of Discrimination Against Women, L.C. v. Peru, Communication No. 22/2009 (2011). UN Doc. CEDAW/C/50/D/22/2009. Para. 7.7.

[19] Human Rights Committee, Mellet v. Ireland. UN Doc. CCPR/C/116/D/2324/2013

[20] Committee on the Rights of the Child, Camila v. Perú, communication No. 136/2021 (2023). UN Doc. CRC/C/93/D/136/2021. Para. 8. 15.

[21] Committee on the Elimination of Discrimination Against Women, *supra note* 16.

[22] Office of the High Commissioner, *supra note* 17.

[23] Committee on the Elimination of Discrimination Against Women, *supa note 16.* Para. 42.

[24] FIGO Committee, *supra* note 15.

treatments.[25] Such laws contribute to violence and mistreatment of women in reproductive health services. Special Rapporteur on violence against women has recognized that such laws contribute to violence and mistreatment of women in reproductive health services.[26]

The International Federation of Gynecology and Obstetrics (FIGO) has recognized that these beliefs can lead to including coercive practices during childbirth and sterilization.[27] As was the case in IV v. Bolivia, where the Inter-American Court of Human Rights recognized that "*woman's freedom to decide and to take responsible decisions with regard to her body and her reproductive health, especially in cases of sterilization, can be undermined by discrimination in access to health care; by the differences in power relationships with the husband, the family, the community and the medical personnel; by the existence of additional factors of vulnerability, and of gender and other stereotypes among health care providers.*"[28]

Gender stereotypes play a crucial role in obstetric violence. The deeply ingrained idea that childbirth is a process that inherently requires suffering leads to disrespect, mistreatment, and coercion during labor and delivery. The Special Rapporteur on violence against women has highlighted that women are often told they should simply be grateful for a healthy baby, while their own physical and emotional well-being is disregarded. [29] Reports have documented severe abuses, including surgical miscarriage procedures, uterine scraping, and post-birth stitching performed without anesthesia. Additionally, many women have been subjected to the "husband stitch", an unethical and harmful procedure in which extra stitches are added after an episiotomy to supposedly enhance a husband's sexual satisfaction, a practice consequence of harmful patriarchal stereotypes and unequal relations between men and women.[30]

The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has similarly acknowledged that women seeking maternal health care face a high risk of ill-treatment, particularly before and after childbirth. The Rapporteur explicitly recognized that these are often driven by stereotypes about women's childbearing roles inflicting physical and psychological suffering that may amount to inhuman or degrading treatment.[31]

Within obstetric violence, racial stereotyping and discrimination has also been documented during childbirth. [32] Examples include Black women being called 'aggressive'; Black and White women being asked different questions reflecting assumptions about their circumstances and 'risk'; not being believed; and the belief that Black women feel less pain. This has led to direct discrimination included health-care staff uttering stereotypical and racist comments.[33]

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[25] Special Rapporteur on Violence Against Women, A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence (2019). UN Doc. A/74/137. Para. 42.
[26] *Id.*
[27] FIGO Committee, *supra* note 15.

[28] Inter-American Court of Human Rights, Case of I.V. v. Bolivia. Preliminary objections, merits, reparations and costs. Judgement of November 30, 2016. Para. 185.
[29] Special Rapporteur on Violence Against Women, supra note 24., para. 46.
[30] Special Rapporteur on Violence Against Women, *supra note* 24., para. 29.
[31] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (2016). UN Doc. A/HRC/31/57. Para. 47.
[32] Kapadia *et al*., Ethnic Inequalities in Healthcare: A Rapid Evidence Review (2022). p. 50. https://www.nhsrho.org/wp-content/uploads/2023/05/RHO-Rapid-Review-Final-Report_.pdf
[33] *Id.,* at p. 32.

2.2. Intersectionality

Specific groups of women face the worst effects of stereotypes, making intersectionality a key approach when considering this topic. Gender is just one factor, but it intersects with race, religion, ethnicity, age, disability, sexual orientation, language, class, and appearance. While stereotypes impact everyone, they do not do so equally.[34]

Based on the belief that are not worthy of procreation, are incapable of making responsible decision regards contraception or they are not a fit to be "good mothers", certain groups of women from minority groups, such as Roma women, indigenous women, women with disabilities and women living with HIV, are more vulnerable to coercive practices, including forced sterilization and abortion.[35]

Women with disabilities are often wrongly perceived as asexual or sexually inactive. This misconception results in a lack of information about their sexual and reproductive health, rights, and available services. This has led to unwanted pregnancy and sexually transmitted infections, and women with disabilities not equipped to make informed decisions about their own bodies, health and lives.[36] Further, the Special Rapporteur on the rights of persons with disabilities has noted that: "girls and young women with disabilities are frequently pressured to end their pregnancies owing to negative stereotypes about their parenting skills and eugenics-based concerns about giving birth to a child with disabilities."[37]

Reports have shown that Roma women experience mistreatment that is discriminatory on the basis of their ethnicity, economic status, place of residence or language.[38] The UN Working Group on Discrimination Against Women and Girls and the Special Rapporteur on minority issues have expressed their concern for Roma women being often subjected to degrading stereotypes, depicted as "fertile" and "promiscuous"; this increases their vulnerability to gender-based violence and forced sterilization.[39]

Rural women are also disproportionately affected by patriarchal gender stereotypes and roles. According to the Working Group, they are particularly vulnerable to harmful practices such as early or forced marriage and female genital mutilation, as well as to violence and poverty. These factors have a profound negative impact on their health. Rural women are often significantly disadvantaged in accessing healthcare services, including reproductive and sexual health care.[40]

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[34] Rangita de Silva de Alwis, *Addressing the Evolving Concept of Gender and Intersectional Stereotypes in International Norm Creation: Directions for a New CEDAW General Recommendation*, (2023), https://papers.ssrn.com/abstract=4466168.
[35] Special Rapporteur on Violence Against Women, *supra note* 24., para. 21.
[36] Special Rapporteur on the rights of persons with disabilities, Sexual and reproductive health and rights of girls and young women with disabilities (2017). UN Doc. A/72/133. Paras. 18 – 20.
[37] *Id.,* para. 31.
[38] Helen L. Watson & Soo Downe, *Discrimination against Childbearing Romani Women in Maternity Care in Europe: A Mixed-Methods Systematic Review*, 14 REPRODUCTIVE HEALTH 1 (2017).; https://reproductiverights.org/wp-content/uploads/2019/04/GLP-SlovakiaRomaReport-Final-Print.pdf
[39] *See,* e.g., UN Working Group on the issue of discrimination against women, *supra note* 8, para. 57; Special Rapporteur on minority issues, Comprehensive study of the human rights situation of Roma worldwide, with a particular focus on the phenomenon of anti-Gypsyism* (2015). UN Doc. A/HRC/29/24. Para. 27.; Gwendolyn Albert and Marek Szilvasi, "Intersectional discrimination of Romani women forcibly sterilized in the former Czechoslovakia and Czech Republic", Health and Human Rights Journal, vol. 19, No. 2 (December 2017).
[40] UN Working Group on the issue of discrimination against women, *supra note* 8, para. 56

Women living with HIV/AID are often seen as promiscuous or drug users, and thus irresponsible. This has led to the idea that they should not raise families.[41] Laws, policies and practices that prevent women living with HIV from bearing children through, for example, forced termination of pregnancy and forced sterilization constitute an extreme form of discrimination.[42]

A case where international organisms have been more silent has been on weight bias. Women also face discrimination in accessing healthcare based on their weight. Weight stereotypes include belief that fat people are lazy, irresponsible, and ignorant about "good "health behaviors.[43] In the context of reproductive health, fat women are subjected to mother-blame as they do not represent dominant cultural ideals regarding what constitutes a good or "fit" mother. Women have reported lack of access to reproductive treatment and stigmatizing treatment experiences in a number of settings in reproductive health care.[44]

3. Conclusions and recommendations

Throughout this document, we have highlighted how gender stereotypes affect women's health by restricting their autonomy, limiting access to health services and affecting their quality of care, especially in the context of reproductive healthcare. These stereotypes impact most severely on women facing intersecting forms of discrimination, including those belonging to racial and ethnic minorities, women with disabilities, rural women, and women living with HIV, among others.

In this context, gender stereotypes are not only the root cause of discrimination faced by women and girls but contribute to health inequities, compromising the principle of health equity and impeding the obligation of States under Article 12 of CEDAW to eliminate discrimination in the field of healthcare.

In this regard, we propose the following recommendations for State parties to be included in General Recommendation No. 41:

- Address stereotypes and discrimination within health systems through mechanisms to identify and eliminate biases, workforce education, and affirmative action strategies.
- Urge states to adopt a gender sensitive curricula in medical and health education to address stereotypes.
- Urge States to remove all legal and factual barriers rooted in gender stereotypes that prevent women from exercising autonomy over their reproductive health. This includes third party consent for medical interventions.
- Urge States to prohibit by law the forced sterilization, as well as other compulsory or involuntary practices that affect their sexual and reproductive that affect their sexual and reproductive health and rights, recognizing that these practices are often driven by harmful gender stereotypes.
- Urge states to decriminalize abortion and incorporate it within comprehensive legal and policy frameworks on health, recognizing that restrictive abortion laws are frequently based on gender stereotypes that undermine women's autonomy.
- Urge States to ensure that adequate procedural safeguards are in place to protect their right to free and informed consent.

[41] Office of the High Commissioner, *supra note 17*.
[42] Working Group on the issue of discrimination against, *supra note* 8, para. 48.
[43] Pamela Ward & Deborah McPhail, *Fat Shame and Blame in Reproductive Care: Implications for Ethical Health Care Interactions*, 6 WOMEN'S REPRODUCTIVE HEALTH 225. p. 226. (2019).
[44] *Id*., pp. 226 – 227.

- Urge States to ensure that healthcare facilities, policies, and practices are inclusive and accessible to all women, regardless of socio-economic status, ethnicity, disability, or other intersecting factors.
- Urge States to ensure the ethical and gender-responsive development and use of health technologies, including artificial intelligence and algorithms, by implementing safeguards against discriminatory biases.
- Urge States to promote diversity in healthcare settings, ensuring diverse representation among healthcare professionals and adopting measures to counteract the influence of gender stereotypes in medical care.

We appreciate the opportunity to present our observations, and hope that our suggestions will lead to the formulation of recommendations that our suggestions will lead to the formulation of recommendations that recognize the impact of gender stereotypes on the health of women and girls.

We remain available to answer any questions the Committee might have in regard to this document. In the meantime, please accept our highest appreciation and regard,

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