



Submission by
HUMAN RIGHTS in CHILDBIRTH

to the

**United Nations Special Rapporteur on Violence against
Women, its Causes and Consequences**

Written Response to:

Call for Submissions issued on UNHCHR website:

*Mistreatment and violence against women during reproductive health care,
with a focus on childbirth*

17 May 2019

Human Rights in Childbirth (HRiC) thanks the UNHCR Special Rapporteur on Violence against Women for providing us with the opportunity to share our observations and collected materials about the violations of human rights during pregnancy and childbirth against women around the globe.

Human Rights in Childbirth (HRiC) is an international, non-profit legal and human rights advocacy and reproductive justice organisation founded in The Hague in 2012 and operating with a diverse board of stakeholders from Australia, Latin America, Eastern Europe, USA and India. We monitor human rights abuses in pregnancy and childbirth around the globe and develop resources to build regional capacity, and train women and gender non-conforming people to advocate for their rights. Historically, the reproductive rights movement has marginalised young women, women of colour and low-income women from leading change in a sphere that has profoundly affected, and continues to affect us. We are working to change this through multidisciplinary research, leadership and capacity building, movement building and by putting the lived, personal experiences of childbearing women at the centre of our discourse.

HRiC has long recognised that the realisation and protection of women's reproductive rights is not a cherry picking exercise. For low-income women, indigenous women, immigrant women and women of colour, in particular, the full spectrum of women's reproductive rights must be defended, together with advocacy to develop the conditions for the realisation of women's human and reproductive rights. These include:

- (a) the right to have a child or to not have a child;
- (b) the right not to be separated from our children;
- (c) the right to be able to care for our children in accordance with our cultural, spiritual and community norms and consistent with the human rights of women and children; and
- (d) the right to control our birthing options, including the right to decide our care providers, birth companions, treatment options and the circumstances of our birth.

Without exception, efforts to elevate any one of these rights at the expense of the other is to place arbitrary limits on a woman's right to bodily autonomy and informed consent, with serious consequences for women and children.

HRIC's mission is to put women at the centre of maternity care, everywhere. Our legal advocacy has ranged from convening multi-stakeholder conferences, building multi-stakeholder support networks and legal expertise, documenting and reporting on the mistreatment of women in pregnancy and childbirth, and strategic intervention in legal cases and parliamentary inquiries at the national level. Through our networks, we seek to set a new standard in engagement for maternity healthcare systems: the integration of grassroots constituencies with state actors, healthcare providers and global health policy developers.

HRiC has been monitoring, and advocating against, the abuse and ill treatment of women in pregnancy and childbirth for seven years now. These observations are based on that volume of experience, knowledge and the testimony of hundreds of people with whom we have spoken and worked with.

Human Rights in Childbirth would like to thank the brave mothers, fathers, doulas, midwives and doctors who have spoken out and worked, often at great personal cost, to protect and support the human rights of pregnant and birthing women around the globe. They are the few - the just - who see and feel the harms that are perpetrated with impunity on birthing women everyday and they will not stand by in silence. They work in isolated and hostile environments in the face of ongoing vertical and horizontal violence, all while fighting a powerful, highly resourced, well coordinated and non-responsive medico-legal culture and social endorsement of the abuse and disrespect of the most vulnerable groups in society. They do all this with very little reward or compensation. We could not have produced this publication without their assistance and compassionate insights. We thank them for their contributions to humanity and to Human Rights in Childbirth.

Table of Contents

<i>Table of Contents</i>	3
Observations	4
<i>Maternal Rights are Human Rights</i>	4
<i>Structural Violence</i>	6
(a) Treating pregnant women as a means to an end.....	7
(b) The impact of religious and financial interests on the lives of pregnant women.....	10
(c) Use of medical fictions to coerce and control.....	12
<i>Maintaining the Cycle of Abuse</i>	13
(a) Dismissing Women’s Complaints.....	14
(b) Poor Monitoring of Mental Health Morbidity following Childbirth.....	16
(c) Publicly Shaming Women for Protecting Themselves in Childbirth.....	16
(d) Silencing Women Who Question Quality of Care.....	19
Responses	21
<i>1) Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth. If so, please specify what kind of cases and describe your country’s response and any good practices, including protection of human rights.</i> 21	
SYSTEMIC FORMS OF ABUSE & DISRESPECT	24
(a) Systemic Culture of Dehumanising Pregnant & Labouring Women.....	24
(b) Violation of the Human Right to Informed Consent and the Right to Refuse Treatment.....	31
<i>Direct Forms of Abuse and Disrespect</i>	53
(a) Violations of the human right to equality and freedom from discrimination.....	54
(b) Violation of the prohibition against cruel and inhuman treatment.....	64
<i>2) Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care;</i>	69
<i>3) Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations;</i>	70
Making a Complaint.....	70
The Civil Justice System.....	73
The Criminal Justice System.....	77
Human Rights Justice System.....	78
<i>4) Does your health systems have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue?</i>	81
<i>Recommendations</i>	82

Observations

Women’s sexual and reproductive health rights are indivisible aspects of human rights, and deeply linked with the fulfillment of all other civil, political, economic, and social rights.¹ To put it simply, healthy happy mothers make for healthy, happy and sustainable communities.

Despite knowing and acknowledging the intrinsic value of mothers to our ability to survive and thrive as a species, the continued lack of recognition of specific maternal rights is, in our view, a significant and ongoing barrier to any sustained improvements in the uptake of women’s rights and the prevention of violence against women. This includes the recognition of rights that indisputably enhance the socio-economic status of women, such as the right not to be separated from our newborns, the recognition of the mother/infant bond in all matters concerning the “best interests of the child”, the right to be remunerated for our work as primary carers of children, the sick and the elderly, and the right to elevated workplace protections for being either pregnant or the primary carer of children, such as government-funded paid maternity leave. In 2019, these rights remain an elusive dream for over 50% of the world’s population.

Maternal Rights are Human Rights

The Universal Declaration of Human Rights only makes one indirect reference to women as mothers, through the paternalistic recognition of “motherhood” as a condition warranting special consideration. Article 25(2), which only entitles women enduring the condition of motherhood to special care and assistance, was largely the result of religious lobbying.² This paternalism has, in turn, influenced the manner in which states have provisioned the delivery of maternity healthcare, through the imposition of “special care” and “assistance” on the state’s terms and conditions, and not by listening to or prioritising the needs of

¹ Gates, Melinda, “Valuing the health and contribution of women is central to global development” *The Lancet*, Volume 386, Issue 9999, 2015, pp. e11-e12; The Lancet Editorial, “Women are the key to sustainable development” *The Lancet*, Volume 386, Issue 9999, 2015, p. 1110.

² A Carlson, ‘Globalizing family values’ (Speech delivered at the Charismatic Leader’s Fellowship, Jacksonville, Florida, 12 January 2004,

<<https://archive.is/20120525091122/http://www.profam.org/docs/acc/thc.acc.globalizing.040112.htm>

mothers. HRiC notes, in the course of our own advocacy, the particular resistance of medical institutions and governments to engage with human rights and ethically trained lawyers in shaping government policy on maternal health. Consumer engagement, if at all offered, is through the cherry picking of advocates either with a limited understanding of funding and accountability structures or seen to be sympathetic to the political strategies of the prevailing government. The result is often the development of ineffectual guidelines or policy initiatives with no funding, no measurable or evaluation requirements, and no accountability mechanisms for improvement. These toothless policy statements are promoted and subsequently used to raise women's expectations that their human rights will be protected when they arrive at a facility, only to find that they have tricked or cheated into putting themselves in the same unsafe situation that has thrived for decades, from which they are unable to extract themselves.³ This, in itself, is a form of abuse and is being perpetrated by high, medium and low income countries, with varying degrees of sophistication. Not surprisingly, the higher the income level, the greater the sophistication used to exclude and manage consumer input.

In 1981, the [Convention on the Elimination of All Forms of Discrimination against Women \(CEDAW\)](#) was introduced to protect women's rights within political, civil, cultural, economic, and social life, but made no mention of maternal rights or the right to be free from violence. In 1993, the [International Declaration on the Elimination of Violence against Women](#) was introduced. Despite the powerful statements contained therein about violence against women, there was no mention in Article 2, of gender based violence towards women in medical facilities. Not surprisingly, there remains considerable resistance, at the state, judicial and stakeholder levels, to acknowledging the extent to which this abuse and disrespect is occurring, at the hands of health care providers, in maternal health facilities.

In relation to maternal rights, CEDAW does not recognise the greater physical, psychological and socio-economic impacts that pregnancy, childbearing and childrearing has on women. The quest for equality, as currently enshrined in human rights instruments, has seemingly erased and, at the same time, diminished the very substance of women that distinguishes us biologically from men. This continues to put women in a subordinate position in society by

³Chattopadhyay, S "Doctor, I can't take it anymore: Sights and Awful Sounds from the Labour Room of an Indian Public Hospital" (31 May 2015) Science and Health at <<http://sohinichattopadhyay.com/2015/06/i-cant-take-it-anymore-sights-and-awful-sounds-from-the-labour-room-of-an-indian-public-hospital/>>; Jomeen, J "The paradox of choice in maternity care" (2011) Journal of Neonatal Nursing (2012) 18, 60-62.

virtue of our pregnancies and unrewarded responsibilities as the primary carers of our children and extended families. Through this systematic subordination, we remain vulnerable to violence, socio-economic dependence, poverty and ill health, and this vicious cycle is maintained for and learnt by our daughters. Time and again, we hear older women telling pregnant women that suffering in childbirth is a woman's lot. In our view, CEDAW will not in its current form provide the mechanisms for adequately addressing desperately needed maternal recognitions and protection against violence.

Structural Violence

In the absence of explicit and recognised maternal human rights, even before she steps in the door of a facility to birth, a pregnant woman is expected to:

- (a) bear the burden of internationally imposed health measures to produce a live baby;
- (b) perform obediently as against undisclosed careprovider interests and mandated facility based policies; and
- (c) meet social expectations of feminized behaviour.

These structures have afforded medical and facility based careproviders with significant power and authority over pregnant women⁴, without appropriate (or, in most cases, any) ethical and human rights scrutiny. Medical education continues to be designed around a medico-legal fiction known as “The Obsteric Dilemma”: where providers assert the medical fiction that mother and unborn fetus have conflicting interests that can only be resolved by ending the pregnancy. A key component of this dynamic, supported by the rise of surveillance technology⁵, is the outrageous presumption that careproviders can authoritatively advocate for the unborn infant to override a woman's wishes.⁶ HRiC notes, in the course of our work, that despite substantial confusion over the status and application of maternal human rights, states and facilities remain resistant to the influence of human rights and ethics based advocacy.

⁴ National Advocates for Pregnant Women, “How Personhood USA and the bills they support will hurt ALL pregnant women” (17 Mar 2009) YouTube Video at <https://www.youtube.com/watch?v=-3X4_p3yAC8

⁵ Kristina Edvardsson,, Ingrid Mogren, Ann Lalos, Margareta Persson and Rhonda Small, “A routine tool with far-reaching influence: Australian midwives' views on the use of ultrasound during pregnancy” *BMC Pregnancy and Childbirth* (2015) 15:195 <DOI 10.1186/s12884-015-0632-y>.

⁶ McLean, Sheila; Petersen, Kerry, "Patient Status: The Foetus and the Pregnant Woman" [1996] *AUJIHRights* 6; (1996) 2(2) *Australian Journal of Human Rights* 229.

With state endorsed power and authority, medical and facility based careproviders are protected from having to disclose financial, personal or religious preferences that undermine or conflict with women's human rights or from the consequences of violating women's human right to informed consent and bodily autonomy by states and governments.⁷

This is a heavy burden to bear for anyone to bear, let alone a pregnant woman in labour facing a team of uniformed, authoritarian medical staff, in a well-coordinated facility designed to support provider convenience above all else.

The result, contrary to the claims of international instruments and states, is the discrete relegation to, and treatment of, pregnant women as occupying a second-class status within their nation states around the globe. This second status is decreed through healthcare policies and administered by facility based careproviders. It is in this context that violations of a pregnant woman's basic human rights to her right to life, privacy, personal autonomy, self-determination, freedom from discrimination and the highest attainable level of her health.

As HRiC reports below, states and health systems only pay lip service to women's rights to choice and self-determination. Through the imposition of structural violations, endless disputes are brought between women and their careproviders about the whether or not the foetus possesses independent moral status. These disputes are inevitably resolved in favour of health systems, supported by states, in order to deliver the indirect but nevertheless powerful message that there is no quality or clarity in relation to maternal rights that health systems cannot abrogate, with ease.

(a) Treating pregnant women as a means to an end

Until the recent advocacy around disrespect and abuse in relation to childbirth, maternal health has been treated as a means to an end: to improve infant mortality and child health. This has, in turn, fueled a top-down technical and medical focus in both the programming initiatives of the World Health Organisation and the funding that is directed towards the delivery of these initiatives. The influence and power of (male dominated) medical institutions to control the discourse around childbirth, and through it, (male dominated) mechanisms for accountability, remain unchanged. It is still the case today, that it is much easier to appeal to organisations such as the Gates Foundation with requests for meaningless deliverables such as the provision of motor bicycles to transport Indian pregnant women to

⁷ Johnsen, D "The Creation of Foetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection" [\(1986\) 95 Yale Law Journal 599.](#)

far flung medical institutions that may or may not be sufficiently staffed (or have safe drinking water) to save lives, than it is to fund a project that aims to educate pregnant women on their legal and ethically based rights in healthcare so they can hold their governments to account. It is not surprising, given that the decision making over allocation of projects and funding remains driven by strategies that, from the beginning, have failed to empower women and continue to treat us as a means to an end, that programme initiatives such as the WHO/UNAIDS agenda for zero discrimination⁸ in healthcare has barely rated a mention at the national levels. Also not surprisingly, women's lack of knowledge and understanding of their rights in pregnancy and childbirth remains a significant, if not primary contributing factor, in the proliferation and perpetration of abuse and disrespect of pregnant and labouring women in facilities - in even the wealthiest of countries and the best appointed facilities.⁹

Equally, states and health institutions have reflected and reinforced the globally endorsed top down medical and technical focus in the provision of paternalistic maternity healthcare. Medical personnel and nurse-midwives are being trained in facilities to prioritise machines and protocols over human beings, and to promote the authority structures of hospital hierarchy at the expense of women's human rights. Doctors are positioned as the most superior person in the birthing room, where they assert a techno-scientific authority to override opposing views and to coerce where "deemed necessary". The resulting normalisation of non-supportive and coercive care is symptomatic of an institutional culture of care that has become dehumanised.¹⁰ Dehumanisation is not about assuming that pregnant women are non-human. It is about assuming that pregnant women are *sub-human*, and from there, they are subjected to a hierarchical stratification which demotes by race, skin colour, socio-economic status, disability and sexuality. A core component of this dehumanisation process is the belief that women are less knowledgeable and therefore less capable of making rational decisions. The stratification changes by country - some will place homosexuality below race in the hierarchy and some will place racial status below, or equal to, socio-

⁸ UNAIDS Programme Coordinating Board. Background note: zero discrimination in healthcare setting. In: UNAIDS/PCB (41)/17.27; 2017 12-14 December 2017.

⁹ Campo, M., "Trust, Power and Agency in Childbirth: Women's relationships with obstetricians." (2010) 22 Outskirts Journal, online edition, <<http://www.outskirts.arts.uwa.edu.au/volumes/volume-22/campo>>.

¹⁰ Smith, David L., "The Essence of Evil: You dont have to be a monster or a madman to dehumanise others. You just have to be an ordinary human being" (2014) Aeon Magazine Online <<https://aeon.co/essays/why-is-it-so-easy-to-dehumanise-a-victim-of-violence>>; Lynn P Freedman, Stephanie A Kujawski, Selemani Mbuyita, August Kuwawenaruwa, Margaret E Kruk, Kate Ramsey & Godfrey Mbaruku (2018) Eye of the beholder? Observation versus self-report in the measurement of disrespect and abuse during facility-based childbirth, Reproductive Health Matters, 26:53, 107-122, DOI: [10.1080/09688080.2018.1502024](https://doi.org/10.1080/09688080.2018.1502024)

economic status. The starting point is always the same - pregnant women are a means to an end.

The dehumanisation process has proven so effective around the globe, that the introduction of female medical personnel has barely altered the power structures or the abuse of labouring women in facilities. If anything, in health systems which thrive on foetal-centric coercion of women, female careproviders appear to outperform males when it comes to patterns of abusing, coercing and torturing women in childbirth.¹¹

HRiC's efforts to draw state and medical stakeholder attention to disrespect and abuse during antenatal care and childbirth has been met with resistance from incumbent managers of health systems. States are shielding stakeholders from human rights advocacy, forcing accountability through expensive and unpredictable legal proceedings. Through this protection, facility based careproviders remain insistent that the inherent features of medical settings, which lend themselves to dehumanising pregnant women, are performed for women's own benefit. This includes de-personalising practices that are now endemic in the provision of maternity healthcare, such as routine episiotomies¹², manual fundal pressure¹³, and the use of routine CTG monitoring¹⁴, reduced empathy and moral disengagement through perceived superiority in the doctor-patient relationship, and the deployment of mechanisation to replace human personnel.

¹¹ Hassan-Bitar S, Wick L, "Evoking the Guardian Angel: Childbirth Care in a Palestinian Hospital" *Reproductive Health Matters* 2007;15(30):103-113; Jardim DMB, Modena CM., "Obstetric violence in the daily routine of care and its characteristics." *Rev. Latino-Am. Enfermagem*. 2018;26:e 3069. [Access 14 May 2019] <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6280177/pdf/0104-1169-rlae-26-e3069.pdf>.> DOI: <http://dx.doi.org/10.1590/1518-8345.2450.3069>.; Bazargan, M & Donnellan-Fernandez, R "An overview of childbirth in Iran: who does the maternity care system serve?" (2016) Conference Paper presented at 11'th International Normal Labour & Birth Conference, Olymic Park, Sydney, Australia (Oct, 2016), <https://www.researchgate.net/publication/309386818_An_overview_of_childbirth_in_Iran_who_does_the_maternity_care_system_serve/references>.

¹² Jiang H, Qian X, Carroli G, Garner P. Selective versus routine use of episiotomy for vaginal birth. *Cochrane Database of Systematic Reviews* 2017, Issue 2. Art. No.: CD000081. DOI: 10.1002/14651858.CD000081.pub3

¹³ Hofmeyr G, Vogel JP, Cuthbert A, Singata M. Fundal pressure during the second stage of labour. *Cochrane Database of Systematic Reviews* 2017, Issue 3. Art. No.: CD006067. DOI: 10.1002/14651858.CD006067.pub3

¹⁴ Alfirevic Z, Devane D, Gyte GML, Cuthbert A. Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. *Cochrane Database of Systematic Reviews* 2017, Issue 2. Art. No.: CD006066. DOI: 10.1002/14651858.CD006066.pub3

When pressed, careproviders seek to justify the abuse and disrespect by asserting that they are themselves the victims of a system with poor working conditions and limited resources.¹⁵ There is some support for this claim - calls for the eradication of maternal and infant mortality during a global financial crisis, whether as part of the Millenium Development Goals or the Sustainable Development Goals, again through the imposition of “top down” targets with a narrow focus on statistical outcomes and a limited understanding of the lived realities of the poor, was only going to place significant pressure on already constrained health systems. The expectation that governments would suddenly respond appropriately to implement structures that both empower women and enhance their health has proven to be an elusive goal. Many health systems, such as in India, responded with strategies that can be only be described as a form of isomorphic mimicry of the global ideal.¹⁶ Limited and fragmented approaches to addressing maternal health so that targets could be seen to be met remains the norm in practice but with one crucial and significant side-effect: the maternal and human rights of women and girls are being gravely undermined in healthcare facilities around the world.¹⁷

(b) The impact of religious and financial interests on the lives of pregnant women

“Pro-life” movements are filling the gap in maternal rights discourse by positioning themselves as the “protectors of mothers”, seeking to influence state and care provider policies to elevate paternalistic forms of institutional service delivery, and through that, the rights of the unborn, against maternal welfare and interests. Calls to investigate, impose forced medical treatment upon, monitor, incarcerate and police pregnant women are

¹⁵ Barbosa Jardim D.M., Modena C .M., “La violencia obstétrica en el cotidiano asistencial y sus características” *Rev. Latino-Am. Enfermagem* 2018;26:e 3069 DOI: 10.1590/1518-8345.2450.3069 www.eerp.usp.br/rlae. Available online at http://www.scielo.br/pdf/rlae/v26/es_0104-1169-rlae-26-e3069.pdf (also available in English)

¹⁶ Das J & Hammer J., “Are Institutional Births Institutionalizing Deaths?” (Blog post 11/20/2014) World Bank Blog: Economics to End Poverty, <<http://blogs.worldbank.org/futuredevelopment/are-institutional-births-institutionalizing-deaths>>

J Das, J Hammer, K Leonard, “The quality of medical advice in low-income countries” (2008) *Journal of Economic Perspectives* 22 (2), 93-114.

¹⁷ Freedman, Lynn P “Implementation and aspiration gaps: whose view counts?” (2016) *The Lancet*, Volume 388 , Issue 10056 , 2068 - 2069.

becoming increasingly prevalent in middle to high income countries.¹⁸ These strategies overwhelmingly affect women who are already vulnerable, and serve a very limited purpose of punishment which does not benefit infants.

Medical education underpinning maternity healthcare continues to promote that paternalism by positioning pregnancy as an abnormal condition, during which the needs of the mother are seen as being in conflict with the needs of the unborn infant, despite substantial medical evidence and human rights law which point to the contrary.¹⁹ This extraordinary medico-legal fiction, coined “The Obstetric Dilemma” is embedded in obstetric education and training. In healthcare facilities funded by pro-life religious interests, mechanisation, withholding information essential to enabling informed choice and consent, and “shroud waving”²⁰ are just some of the many tactics employed to manage and coerce women into submission. Through the use of systemic structures, careproviders easily assert themselves as the only “expert” capable of speaking on behalf of the unborn fetus. There is no evidence to suggest that careproviders are better able to predict an unborn infant’s needs over the mother or any scientific evidence to support the existence of the “obstetric dilemma”.

Women are not made aware that their care provider or the facility in which they are birthing has pro-life leanings, which in turn, determines the type and standard of care that they are provided. In secular countries, pro-life leanings of careproviders are not disclosed to women. In pro-life controlled countries, it is being used as a tool to control women in healthcare facilities. This practice is state condoned and, in many instances, state endorsed. The cruel neglect and agonising death of Savita Halappanavar through maternal sepsis is a classic example of the indivisibility of reproductive rights for childbearing women and what

¹⁸ Queensland Police Union, “Submission to the Child Protection Inquiry re Rights to the Unborn” (2011 <http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0009/172692/Queensland_Police_Union.PDF>); Paltrow, LM & Fravin, J., “Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women’s Legal Status and Public Health” (2013) *Journal of Health Politics, Policy and Law*, Vol. 38, No. 2, April 2013: DOI 10.1215/03616878-1966324

¹⁹ Mackenzie T B, Nagel T C and Rothman, B J K “When a Pregnant Woman Endangers Her Foetus” (1986) 16 (1) *Hastings Center Report* 24, 25; Karpin I “Legislating the Female Body: Reproductive Technology and the Reconstructed Woman” (1993) 3 *Columbia Journal of Gender and Law* 325 at 329; Mattingly, S S “The Maternal-Foetal Dyad: Exploring the Two-Patient Obstetric Model” (1992) Vol 22 No 1 *Hastings Center Report* 13.

²⁰ The practice of repeatedly telling women, without basis, that their babies are going to die if they do not comply or that their actions are contributing to the deaths of their newborns, also known as “waving the dead baby card”; Hall, W. A., Tomkinson, J. and Klein, M. C. (2012) ‘Canadian Care Providers’ and Pregnant Women’s Approaches to Managing Birth: Minimizing Risk While Maximizing Integrity’, *Qualitative Health Research*, 22(5), pp. 575–586. doi: [10.1177/1049732311424292](https://doi.org/10.1177/1049732311424292).

happens when women are placed in the hands of a careprovider with undisclosed religious or financial interests that are in conflict with women's human rights.²¹ Ms Halappanavar was a young Indian-born dentist living in Ireland, who was denied an abortion despite presenting with a confirmed miscarriage of a planned pregnancy. She was vulnerable and entirely dependent on the health system to care for her. A formal, independent report identified 3 medical causal factors contributing to her untimely death, namely inadequate assessment and monitoring, a failure to offer all management options to her, including abortion, and non adherence to clinical guidelines related to the prompt and effective management of sepsis. For women of colour navigating health facilities in Anglo-Celtic dominant countries, this is trite news. Women of colour in middle to high income countries frequently report that their concerns are ignored or dismissed, that they are subjected to unwanted treatments, and that they face racism and disrespect when they question their careproviders.²²

(c) Use of medical fictions to coerce and control

Pitting the interests of mothers against the interests of their unborn infants in the provision of care, whether for religious or financial interests, has undoubtedly exacerbated the abuse and mistreatment that women experience in pregnancy and childbirth, in direct violation of a pregnant woman's human rights. Underpinning this artificial imposition of a medically constructed conflict is the belief that an unborn fetus is entitled to a right to life which competes with or overrides a woman's rights to self determination, life and the highest attainable level of health of the woman. These undisclosed beliefs can put pregnant women in such care at serious risk. The idea²³ that a fetus may need protection against the mother whose body, brain and life choices have been redirected to prioritising her pregnancy and unborn baby belies any rational thought and is based on archaic and dangerously misogynist attitudes towards women. That said, it is a medically constructed belief that continues to underpin the provision of maternity healthcare and detracts from the quality of care that women are entitled to, in keeping with their right to the highest attainable standard of care.

²¹ M Berer, "Termination of pregnancy as emergency obstetric care: the interpretation of Catholic health policy and the consequences for pregnant women: An analysis of the death of Savita Halappanavar in Ireland and similar cases" *Reproductive Health Matters* 2013;21(41):9–17

²² Bowers, Fergal, "Midwife confirms she told Savita Halappanavar Ireland a 'Catholic country'" (11 Apr 2013) *Raidió Teilifís Éireann*, <<https://www.rte.ie/news/health/2013/0410/380613-savita-halappanavar-inquest/>>

²³ Savulescu J & de Crespigny L, "Should it be a crime to harm an unborn child" (2014) *The Conversation* (21 Mar).

It has and continues to have devastating implications for women's lives.²⁴ In other words, when health care providers operate under a misinformed belief that they have two patients in one body²⁵ and that the life of the foetus is more important than that of the mother, they are more likely to subject the mother to more invasive procedures, even against her wishes.

Maintaining the Cycle of Abuse

The structural violence that women endure in facility based care does not operate in a social vacuum. As noted above, through and with the authority and powerful status designated to them by international instruments, funding structures and states, facility based care providers confidently pursue a strategy of controlling and coercing women in circumstances that go beyond the facilities in which they operate. These strategies serve the dual effect of both maintaining the cycle of structural violence within facilities but also perpetuating social beliefs of the subordinate class of pregnant women within society and states. In this way, pregnant women are easily policed, both within and beyond the facilities, in a pervasive manner that has proven extremely effective in normalising the abuse to a point where society and care providers no longer recognise nor care to address the health effects on pregnant women or the social impact on the human rights of ALL women.

These strategies include:

- (a) Dismissing Women's Complaints as ignorant, misplaced or aimed at an ulterior purpose;
- (b) Ignoring, denying and/or failing to adequately monitor the psychological harms that result from poor quality care in facilities;
- (c) Publicly shaming women for taking independent steps to protect themselves in childbirth;
- (d) Silencing and punishing women who question treatment recommendations.

²⁴ In re A.C. (District of Columbia. Court of Appeals. Atl Report.)1987 Nov 10; 533:611-7; Laxmi Mandal v Deen Hayal Harinager Hospital & Ors 8853/2008, on 15 December 2008 (Delhi High Court), <https://docs.escri-net.org/usr_doc/HRLN_Summary_-_Laxmi_Mandal_v_Deen_Dayal_Hospital.pdf>, Rebecca and Wayne, Katherine, "Pregnancy, Birth, and Medicine", The Stanford Encyclopedia of Philosophy (Spring 2018 Edition), Edward N. Zalta (ed.) <<https://plato.stanford.edu/archives/spr2018/entries/ethics-pregnancy/>>. See examples of the said implications in Chapter 3.2 Overriding Autonomy: Forced Interventions During Pregnancy.

²⁵ de Crespigny L, Savulescu J, "Homebirth and the Future Child" Journal of Medical Ethics 2014;40:807-812; McLachlan, H "There is no moral imperative for women to give birth in hospital" (2014) The Conversation <<https://theconversation.com/there-is-no-moral-imperative-for-women-to-give-birth-in-hospital-22732>>

Without this extension of social control over maternal human rights and the discourse surrounding women's human rights, it would not be possible for the cycle of abuse to proliferate and perpetuate as it has over the last 2 decades.

(a) Dismissing Women's Complaints

The reporting of mistreatment and violence against women during pregnancy and childbirth, and the failure of states to acknowledge, let alone address, that mistreatment and violence, is not a new or novel occurrence. Ignoring women's complaints about their treatment in childbirth has become as normal as abusing and disrespecting women in pregnancy and childbirth. It forms an essential part of the continuing cycle of abuse in maternity healthcare. Take, for example, the current discourse about high levels of maternal mortality amongst African American and indigenous American women in the USA. These issues were reported by Amnesty International in 2010 as a crisis in maternal health care in the USA at that time.²⁶ Since then, despite the steady rise in maternal mortality amongst this same cohort in the USA, there remains a stark difference of opinion between careproviders and women as to both the causes and the solutions to this crisis.²⁷ Careproviders appear to have forgotten the prognostic uncertainty that can arise in all medical encounters or the real possibility that evidence does not support their manner of practice.²⁸ This, combined with the growing tendency to coerce, control and punish pregnant women with the aid of states, is having a disproportionate impact on the lives and civil liberties of pregnant and birthing women around the globe. With state and medical professional endorsement, not even status can alleviate the punitive and socially demeaning attacks that pregnant women face for their choices, and that seems to have become a common social practice.²⁹ The most recent estimate is that, of the women who access healthcare, 45.5% experience childbirth as traumatic, consistent with criterion A of the DSM-IV. Of these, approximately 10–18% of women develop severe PTS Symptoms without meeting all criteria for full PTSD-Post Childbirth (PTSD-PC). A recent meta-analyses identified the prevalence of full PTSD-PC in community

²⁶Amnesty International, 'Deadly Delivery: The Maternal Health Care Crisis in the USA', (Report, Feb 2010) <<https://www.amnestyusa.org/files/pdfs/deadlydelivery.pdf>>

²⁷ Lemore, M., Saint Louis, D & Scott, KA, "For OB-GYN Group, Recent Social Media Flap Should Be a Wakeup Call" (*ReWire News: May 8 2018*) at <<https://rewire.news/article/2018/05/08/ob-gyn-social-media-wakeup-call/>>, downloaded 14 May 2019.

²⁸ K. Prusova *, L. Churcher *, A. Tyler & A. U. Lokugamage, "Royal College of Obstetricians and Gynaecologists guidelines: How evidence-based are they?" *Journal of Obstetrics and Gynaecology*, November 2014; 34: 706–711

²⁹ Ed, "Meghan Markle sparks debate at global obstetrics summit" *The Business Telegraph* (5 May 2019) <<https://www.businesstelegraph.co.uk/meghan-markle-sparks-debate-at-global-obstetrics-summit/>>.

populations and high-risk populations to be 4% and 18.5% respectively.³⁰ The most important factor to predispose PTSD-PC is a woman's subjective experience of childbirth, within which interpersonal factors and quality of provider interaction mattered the most.³¹

Women have been advocating for their right to birth in a safe and respectful environment for over 55 years.³² In 1958, after a distressing stay in hospital for the birth of her child, Sally Willington published a letter in a newspaper asking if other women had shared her experiences in childbirth:

*'In hospital, as a matter of course presumably, mothers put up with loneliness, lack of sympathy, lack of privacy, lack of consideration, poor food, unlikely visiting hours, callousness, regimentation, lack of instruction, lack of rest, deprivation of the new baby, stupidly rigid routines, rudeness, a complete disregard of mental care or the personality of the mother.'*³³

This complaint is chillingly similar to, but in many ways, much better than the complaints and written requests for assistance that HRiC receives nearly everyday since the launch of our website in 2013. We receive complaints ranging from Trinidad & Tobago to Australia, detailing the physical and mental abuse that women endure in childbirth in facilities and, despite the change in location and the names used, the details are chillingly similar.

Despite the consistency over decades in the composition and content of complaints by women of systemic and procedural forms of abuse and disrespect, the medicalised health system developed in the UK not only remains impervious to the demands of UK women as consumers, these dehumanising health systems have been exported from the United Kingdom to the most of the colonised and settler countries around the globe, to the detriment of pregnant women everywhere. The discriminatory practices inherent in the effort to

³⁰ Yildiz, P. D., Ayers, S., & Phillips, L. (2017). The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders*, 208, 634–645. doi:10.1016/j.jad.2016.10.009

³¹ Jenny Patterson, Caroline Hollins Martin & Thanos Karatzias (2019) PTSD post-childbirth: a systematic review of women's and midwives' subjective experiences of care provider interaction, *Journal of Reproductive and Infant Psychology*, 37:1,56-83, DOI: [10.1080/02646838.2018.1504285](https://doi.org/10.1080/02646838.2018.1504285)

³² Henci Goer, *Cruelty in Maternity Wards: Fifty Years Later*, 19 J. PERINATAL EDUC. 33, (2010).

³³ Davis, A "Choice, policy and practice in maternity care since 1948", (2013) *History and Policy Papers* (Warwick University), <<http://www.historyandpolicy.org/policy-papers/papers/choice-policy-and-practice-in-maternity-care-since-1948>>.

colonise have been translated to the health systems of settler countries. Ignoring women's concerns and needs is embedded into these healthcare systems.

(b) Poor Monitoring of Mental Health Morbidity following Childbirth

The consequences of disrespectful maternity care are indisputably impacting women's physical and psychological health, and through that, the health of their newborns.³⁴ In high income countries, low maternal and infant mortality rates are shielding the rise in maternal and infant morbidity³⁵, including morbidity that is inadequately monitored, such as post-natal depression, undiagnosed PTSD and maternal suicide following childbirth.³⁶ Limiting the obligation to report pregnancy related harms to 12 months after the birth will never do justice to the mothers who struggle to cope with, and silently endure, PTSD and post-natal depression and morbidities such as fecal and urinary incontinence following childbirth. About their traumatic birth experiences, some women assert that they felt raped during the birth of their babies, by their health care providers.^{37 38}

(c) Publicly Shaming Women for Protecting Themselves in Childbirth

Women have responded to States' failures to provide safe and respectful birthing environments in different ways.³⁹ A greater percentage of women are requesting elective Cesarean sections in order to avoid the pain and suffering now associated with facility based

³⁴ Samantha Reisz, Jessica Brennan, Deborah Jacobvitz & Carol George (2019) Adult attachment and birth experience: importance of a secure base and safe haven during childbirth, *Journal of Reproductive and Infant Psychology*, 37:1, 26-43, DOI: 10.1080/02646838.2018.1509303;

³⁵ Geller SE, Koch AR, Garland CE, MacDonald EJ, Storey F & Lawton B, "A global view of severe maternal morbidity: moving beyond maternal mortality" (2018) *Reproductive Health* 2018, 15(Suppl 1): 98 <<https://doi.org/10.1186/s12978-018-0527-2>>

³⁶ Tracey White, Stephen Matthey, Kim Boyd & Bryanne Barnett (2006) Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence, *Journal of Reproductive and Infant Psychology*, 24:2, 107-120, DOI: 10.1080/02646830600643874

³⁷ See for instance, the comments to the website section "What's birth rape" at <https://birthraped.wordpress.com/whats-birth-rape/>

³⁸ Studies indicate that the symptoms, manifestations and discourse of Obstetric Violence survivors are similar to those of war and rape survivors. See for instance: Kitzinger, S. "Birth as rape: There must be an end to 'just in case' obstetrics" *British journal of midwifery*, ISSN: 0969-4900, 09/2006, Volume: 14 Issue: 9 Page: 544-545 DOI: 10.12968/bjom.2006.14.9.21799

³⁹ Adriana Arcia. US nulliparas' perceptions of roles and of the birth experience as predictors of their delivery preferences. *Midwifery*, 2013; DOI: 10.1016/j.midw.2012.10.002.;

childbirth. As we note below, these requests are met with very little resistance, particularly in for-profit facilities around the globe, with medical professionals defending “women’s right to choose”. With the advent and growth of the provision of women-centred maternity care practice led by independently practising midwives, a growing number of women are seeking to birth away from health facilities with a skilled midwife by their side.⁴⁰ Women understand that the risk of suffering harmful interventions and other forms of obstetric violence during the birth process are significantly lower in home birth.⁴¹ While planned home birth is a safe option for low-risk pregnancies in well integrated health systems⁴², access to the service remains elusive as incumbent stakeholders resist this option. This is a violation of the fundamental maternal human right to choose how, where, when and with whom women give birth. It perpetuates the cycle of abuse by denying the suffering that women are enduring in hospitals and exposing them to the significant risk of suffering obstetric violence in hospital settings.

Facility personnel response to women seeking to birth outside facilities is markedly different to the way in which maternal requests for Cesarean section is managed. In any other market, women exercising a better quality service would simply be seen as informed consumers voting with their feet, availing themselves of alternate options: even if not ideal, the perception of women is that this alternative to hospital provides the safety and dignity they seek in childbirth.⁴³ This should be a cue to healthcare providers to look at their operating systems and make adjustments. In maternity healthcare, however, rather than reflect on their practices, the practice options of *women* is constantly ridiculed and vilified in ways that diminish the concerns of women and ridicule them for seeking to physically and psychologically protect their health:

⁴⁰ Catling, C, Dahlen HG, Homer, SE “The influences on women who choose publicly-funded home birth in Australia” (2014) *Midwifery Journal* Vol 30(7) pp 892 -898.

⁴¹ For more information and access to up to date research regarding home birth and tools to measure respectful maternity care, please visit <https://www.birthplacelab.org/homebirth-an-annotated-guide-to-the-literature/> The Birth Place Lab, in the Division of Midwifery at the University of British Columbia facilitates multi-disciplinary research, community-based participatory research, and knowledge translation around access to high quality maternity health care across birth settings.

⁴² Olsen O, Clausen JA. Planned hospital birth versus planned home birth. *Cochrane Database Syst Rev*. 2012;9(9):CD000352. Published 2012 Sep 12. doi:10.1002/14651858.CD000352.pub2 (Available online at <http://www.ncbi.nlm.nih.gov/pubmed/22972043>).

⁴³ Nicholls, M (Jumped or pushed? Insights gained from a homebirth review conducted in Western Australia show that the decision to have a homebirth is more complex than is often assumed.” (2011) *O&G Magazine*, Vol 13 No 4 Summer p 35.

"We do not support programmes that advocate for, or individuals who provide, home births. Childbirth decisions should not be dictated or influenced by what's fashionable, trendy, or the latest cause célèbre."

Statement by American Congress of Obstetricians and Gynaecologists

It would seem that no woman is safe from the public shame and ridicule that follows from seeking to protect herself in childbirth, even if from discrimination, ill-treatment or racism - not even England's Duchess of Sussex.⁴⁴ ACOG's brazen statement, made in the face of a global C-section epidemic, and the documented exposure of significant racial discrimination and profiling in the health systems of UK⁴⁵, USA⁴⁶, Canada⁴⁷ and Australia⁴⁸ causing higher rates of maternal mortality amongst women of colour, is indicative of the power of the medical hegemony to control and override informed choice. Medical associations are regularly and publicly humiliating and vilifying women, even those who have suffered adverse homebirth events.⁴⁹ This is a socially endorsed public abuse of women.

⁴⁴ Cited in Ed, "Meghan Markle sparks debate at global obstetrics summit" The Business Telegraph (5 May 2019) <<https://www.businesstelegraph.co.uk/meghan-markle-sparks-debate-at-global-obstetrics-summit/>>.

⁴⁵ Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.), "Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16" Oxford: National Perinatal Epidemiology Unit, University of Oxford 2018 <<https://www.npeu.ox.ac.uk/downloads/files/mbrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf>>

⁴⁶ Martin N & Montagne R, "Nothing Protects Black Women From Dying in Pregnancy and Childbirth: Not education. Not income. Not even being an expert on racial disparities in health care." (2017) ProPublica, NPR News Dec. 7, 2017 <https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth?utm_content=buffer19e75&utm_medium=social&utm_source=facebook&utm_campaign=buffer&fbclid=IwAR0qFnFagkE91rCwNdQZQ9WcbLtHe_E7Cn5BUOqsALB_xW6ZvPbuLEbeuzI>.

⁴⁷ Higginbottom GMA, Morgan M, Alexandre M, Chiu Y, Forgeron J, Kocay D and Barolia R, "Immigrant women's experiences of maternity-care services in Canada: a systematic review using a narrative synthesis" (2015) BioMed Central Systematic Reviews 4:13 <<https://doi.org/10.1186/2046-4053-4-13>>; Denize et al. (2018), Addressing cultural, racial and ethnic discrepancies in guideline discordant gestational weight gain: a systematic review and meta-analysis. PeerJ 6:e5407; DOI 10.7717/peerj.5407

⁴⁸ Kildea S, Tracy S, Sherwood J et al (2016) Improving maternity services for Indigenous women in Australia: moving from policy to practice. Med J Aust 205(8): 374-79

⁴⁹ Gartry L & Arrow B, "Women ignoring medical advice on homebirths 'selfish', peak medical body says" ABC News Australia (18 June 2015) <<https://www.abc.net.au/news/2015-06-18/women-choosing-homebirths-selfish-peak-medical-groups-says/655566>>

The polarisation of “home versus hospital” as a measure of relative risk does not provide women with the safe and respectful options that they are seeking in birth. The implicit messaging in these blatant attacks on women who choose to homebirth is that women are expected to endure facility based abuse and disrespect, and to sacrifice their bodies in order to birth our infant. In countries like India, careproviders are even more flippant about the physical and mental sacrifice women are expected to make when asserting their views about homebirth. This, in turn, is based on the discriminatory denial of the reality that women are the primary carers of our neonates - damaged or otherwise, we face the responsibility of caring for our infants. Our ability to love and provide care is being severely undermined by those who claim to be our careproviders, who also presume that we must suffer, both physically and psychologically, in childbirth.

(d) Silencing Women Who Question Quality of Care

Debate about the relative risks around homebirth have been effective in silencing women and preventing them from holding their governments to account for failing to properly integrate homebirth with the necessary infrastructure in the provision of healthcare. In medium to high income countries, this is a denial of a woman’s right to the highest attainable level of health. Questions remain around training and collaboration guidelines, relative responsibilities, competitive neutrality for privately practising midwives, adequate insurance coverage, the provision of respectful ambulatory services and the attitudes of obstetricians towards midwifery as an independent profession. Then there is the obvious: the blanket prohibition by medical practitioners to attend or support homebirth is inconsistent with the claim that women’s choices should be respected.

“You need three things in order for women to be free to choose home births,” says Dr Leonie Penna, a consultant in foetal medicine and obstetrics at King's College hospital. “You need women who want a home birth, you need a supportive infrastructure and you need midwives who are happy to deliver it. Unfortunately, we obstetricians undermine the first two – and sometimes even all three. By our nature, we are very risk averse. Many of us blow out of proportion the risk inherent in home births, counselling women against it in a very paternalistic way. The fewer women chose it, the

*more the infrastructure is weakened. Then midwives begin to lose confidence, and suddenly the entire structure becomes shaky.*⁵⁰

Restricting or limiting women's choices in childbirth has proven ineffective in shifting the powerful drive women are experiencing to protect themselves and their babies from the abuse and disrespect experienced in facilities. Women are withdrawing from formal healthcare systems because of unmet needs, even if they are unable to obtain a skilled attendant to support them.⁵¹ This phenomenon, known as freebirth, is a growing trend in middle to high income countries, despite punitive measures undertaken to control these efforts. In low income countries, recent studies indicate that women are returning to their communities and seeking traditional forms of care in childbirth in order to avoid the abuse and disrespect provided at the hands of facility careproviders.⁵²

The failure of health systems to recognise the importance of respecting women's attempts to protect themselves points to either a limited understanding of the aetiology of trauma and avoidance⁵³, or a measure of the true value attached to the physical and mental health of pregnant women.

⁵⁰ Hill, A, "Home birth: 'What the hell was I thinking?'" (2011) The Guardian (16 Apr 2011)
<<https://www.theguardian.com/lifeandstyle/2011/apr/16/home-birth-trial-or-rewarding>>

⁵¹ Holten A, de Miranda E, (2016) "Women's motivations for having unassisted childbirth or high-risk homebirth: An exploration of the literature on 'birthing outside the system'" Midwifery, Volume 38, 2016, pp. 55-62; Dahlen, H, Kumar-Hazard B & Schmied, V, (eds) The Canary in the Coalmine: why women are making extreme choices in childbirth, (Routledge, Sydney, forthcoming publication).

⁵² Mannava, P; Durrant, K; Fisher, J; Chersich, M; Luchters, S, "Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review" (2015) Globalization and Health; London Vol. 11, (2015).

⁵³ Dr Gill Thomson & Soo Downe (2008) "Widening the trauma discourse: the link between childbirth and experiences of abuse" Journal of Psychosomatic Obstetrics & Gynecology, 29:4, 268-273, DOI: 10.1080/01674820802545453

Responses

1) Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth. If so, please specify what kind of cases and describe your country's response and any good practices, including protection of human rights.

Women are abused and disrespected in pregnancy and childbirth through:

- (a) Systemic structures: the use of structures, policies, rules and state support mechanisms (police, courts, child protection services) to bully, control and coerce pregnant women;
- (b) Direct action: actions, recognisable behaviours, random punishments, cruel and inhuman treatment, discrimination.

These direct and systemic forms of abuse work in a symbiotic and integrated fashion to achieve the end result, which is a process of coercion and control of pregnant and birthing women to achieve an outcome - a live baby.

We start with the systemic forms of abuse below because the existence of these structures, and the environment they provide for the easy abuse of pregnant women, is vehemently denied by health care systems across the world. It is clear, from HRiC's observations of maternity wards *around the globe*, that these systemic forms of control are critical for creating a climate of abuse and disrespect. Further, the more sophisticated, underhanded and protected these systemic structures of abuse, the more prevalent and commonplace the direct actions of abuse and disrespect. These systemic structures create the context in which a culture of dehumanising and consequently "normalising" abuse and disrespect of pregnant and vulnerable women can thrive.

Over time, these systemic cultures have developed sufficient dominance to become endemic and self-sustaining both within and across health facilities. Facility personnel who do not adapt, perpetrate or deliberately blind themselves to the abuse and disrespect are quickly

managed out of the health system. This trend is overwhelmingly affecting young midwives who have been trained to provide woman centred care.

The USA is an excellent example of that combination of highly sophisticated systemic structures of abuse and the consequent direct actions of facility personnel. In a country where the rise in Cesarean section and intervention rates is matched only by the rise in maternal and infant mortality, it is obvious that state and health system *priorities, rather than resources*, are contributing to a systemic culture of abuse and disrespect within facilities.

Repeat reports about the alarming rise in Cesarean birth rates for the last 10 years, particularly among the richest fifth of countries, are falling on deaf ears. Through policy platforms focussed on efficiency and shifting the burden of public healthcare costs, states are implementing privatised healthcare systems while depleting resources in public health facilities as a means of encouraging maternity consumers to shift off the public purse and on to profit making institutions.⁵⁴ The obvious impact of shifting a life-saving procedure into the hands of profit making enterprises is to create substantial within country economic inequalities in relation to cesarean surgery. These inequalities might be due to a combination of inadequate access to emergency obstetric care among the poorest subgroups and high levels of caesarean use without medical indication in the richest subgroups, especially in middle income countries.⁵⁵ Economists at the University of Toronto analysed data from nearly 5 million hospital records between 1994 and 2010 in Canada, and found that where doctors earned twice as much for a C-section as for a vaginal delivery, they were more likely to choose it than when the two procedures were paid the same.⁵⁶ That trend is also developing in middle to low income countries, such as India, the Dominican Republic, Iran, and most of Latin America, where private maternity healthcare systems are rapidly growing and encouraged by governments. The researchers found large inequalities between countries, with national cesarean birth rates ranging from 0.6% in South Sudan to 58.9% in the Dominican Republic. The rates tended to be lower (<10%) in the poorer two fifths, likely

⁵⁴ Einarsdóttir K, Kemp A, Haggar FA, Moorin RE, Gunnell AS, et al. (2012) Increase in Caesarean Deliveries after the Australian Private Health Insurance Incentive Policy Reforms. PLOS ONE 7(7): e41436. <<https://doi.org/10.1371/journal.pone.0041436>>

⁵⁵ Boatina Adeline Adwoa, Schlottheuber Anne, Betran Ana Pilar, Moller Ann-Beth, Barros Aluisio J D, Boerma Tieset al. Within country inequalities in caesarean section rates: observational study of 72 low and middle income countries BMJ 2018; 360 :k55.

⁵⁶ Ed., “Caesar's legions; Childbirth” The Economist; London Vol. 416, Iss. 8951, (Aug 15, 2015): 53-54.

representing underuse, and greater (>15%) in the richer two fifths, often representing overuse.

It is unconscionable to subject vulnerable women, in war torn and poverty stricken regions like India's Kashmir⁵⁷ and Syria, to major abdominal surgery unless medically warranted. There is a complete disconnect between the provision of facility based medical services and the lived experiences of women with lower socio-economic status or who live in extreme poverty. Early discharge, expensive pain medicine, poor quality care, facility infections and lack of antibiotics are all very real consequences for a healthy, capable woman who just wants to give birth, and has probably already done so with much less, in her own home, with a traditional birth attendant. The obligation to continue with their household and caring responsibilities, time to recover, access to pain relief or acute care or medicines in the event of complications are not being factored into the considerations of facility personnel who are pushing for managed childbirth outcomes - whether for financial advantage or convenience or both.

We ask the Special Rapporteur to consider the relationship between Systemic Forms of Abuse and Disrespect, and the unprecedented and alarming rise in Cesarean section rates around the globe. The claim that Cesarean section rates are increasing by reason of maternal demand must be tested. Given, as set out below, how little women understand about the systemic strategies used to control and coerce them in childbirth and the lengths taken to conceal this information from them, it is not at all surprising that some women simply elect for Cesarean section. Questions must be asked, however, as to whether the women are making an informed choice or whether they are in fact simply seeking to escape the abuse and disrespect in childbirth that is being reported by their friends and family members. HRiC knows from our reports, that providers are not discouraging of these conversations, particular in for-profit facilities. There develops a cyclical and self perpetuating dynamic of abuse where, by reason of the financial gains for medical professionals, there is no institutional incentive for facility based management (most often also medical professionals) to fix these systemic forms of abuse and disrespect.

For example, in the case of an unscheduled Cesarean section recommended when labour is “not progressing”, it is extremely rare to find a woman, not already a careprovider, who knows or understands that their hospital imposes strict time limits on different stages of

⁵⁷ Nissa, Z “Why are cesarean births in JK 'alarminglly' high?”(2018) Greater Kashmir (Srinagar, October 24, 2018, 10:02 AM) <<https://www.greaterkashmir.com/news/opinion/why-are-cesarean-births-in-jk-alarminglly-high/>>.

labour *when it is rarely, if ever, disclosed to them, before hand?* Doctors and midwives also grow impatient if labour is not progressing swiftly enough, particularly at the end of a shift or before a weekend. An analysis of three years of American data by Consumer Reports, a non-profit magazine, found that far fewer babies were born on public holidays.⁵⁸ Women are suddenly told that “they are out of time” or “not allowed to keep labouring” or that “their baby will die”. Many women, regardless of country, report feeling shocked, unprepared or bamboozled by the sudden, intensive change in approach, which was more often than not, preceded by hours of neglect. Any decision, in this grey area of whether to continue labouring or to proceed with an unscheduled Cesarean section, is hardly made on an informed basis when one party is using undisclosed policy or guidelines to mandate responses from women. The “consent” that is finally given is more of a concession, where women simply give up after hours of badgering, taunting or abuse.^{59 60}

SYSTEMIC FORMS OF ABUSE & DISRESPECT

(a) Systemic Culture of Dehumanising Pregnant & Labouring Women

HRiC notes above that the policy directives, adherence to outcomes, and the education and training of medical and facility personnel appears to encourage the treatment of pregnant women as a means to an end in facilities for childbirth. Through the use of structures set up to support, protect and prioritise the interests of facility personnel, careproviders have developed practice through the process of dehumanisation by omission. Dehumanization by omission does not necessarily involve an active decision to suppress the humanity of another. It is where the dehumanisation process is passively triggered by contextual and individual suppression of the humanity of a particular sub-group. Concerningly, the primary factors identified below as contributing to dehumanisation by omission⁶¹ reflect the typical context and behaviours of careproviders in childbirth facilities:

⁵⁸ Haelle, T “Your Biggest C-Section Risk May Be Your Hospital: Consumer Reports finds that your odds of having a c-section can be over nine times higher if you pick the wrong hospital” (2018) Consumer Reports (10 May) <<https://www.consumerreports.org/c-section/biggest-c-section-risk-may-be-your-hospital/>>

⁵⁹ Betrán AP, Ye J, Moller AB, Zhang J, Gülmezoglu AM, Torloni MR. The Increasing Trend in Caesarean Section Rates: Global, Regional and National Estimates: 1990-2014. PLoS One. 2016;11(2):e0148343. Published 2016 Feb 5. doi:10.1371/journal.pone.0148343.

⁶⁰ Christophe Clesse, Joëlle Lighezzolo-Alnot, Sylvie De Lavergne, Sandrine Hamlin & Michèle Scheffler (2018) Statistical trends of episiotomy around the world: Comparative systematic review of changing practices, Health Care for Women International, 39:6, 644-662, DOI: 10.1080/07399332.2018.1445253

⁶¹ Waytz, A., & Schroeder, J. “Overlooking Others: Dehumanisation by Omission and Commission” (2014) TPM Vol. 21, No. 3, September 2014

(a) Outcome Irrelevance

Careproviders devote less resources to, and seek less social information about, individuals with whom they do not expect future interaction (in other words, a common feature of fragmented care within facilities);

(b) Social Connection

Careproviders who develop social connections with their dominant group (i.e. facility personnel) attribute fewer mental states to others, and report that others were less worthy of moral concern because these “others” lacked or falsely portrayed feelings and emotions. This factor is especially relevant to the defensiveness and lack of engagement by careproviders when called to account for abuse and disrespect;

(c) Goal Instrumentality

Whereas birthing women are often afforded little attention because they are outcome irrelevant or socially irrelevant, when they become necessary to fulfill a goal (such as pushing out the baby) they are afforded a great deal of attention — only NOT to their intrinsic value as humans, but instead to their extrinsic utility to complete the goal of a producing a live baby. Because the careprovider attention is limited and finite, this focus on instrumentality can lead to a passive neglect of the woman’s essential humanity, seen to be outside the scope of the focal goal. In other words, pregnant women, who are instrumental for improving infant mortality scores, are treated like tools only, used to fulfill that purpose. This reflects the women’s stories of the doctor appearing as they are in the pushing stage of labour, to demand action and compliance in accordance with the doctor’s wishes, together with the use of unconsented treatments such as manual conversion or removal of the placenta or stitching without pain relief, just to get the “job done”.

(d) Possession of Resources such as Status, Power and Money

Careproviders enjoy relatively higher status, power, and money which encourages thinking and behaviour to reflect perceived superiority, less cognitive attention to others, greater narcissism, all of which can contribute to the process of dehumanization. Consequences include increased unethical behavior, reduced prosocial behavior, feelings of powerfulness and greater disengagement during social interactions. Powerful people tend to objectify others and consider them more in

terms of extrinsic utility than intrinsic worth as humans. A final pervasive resource that seems to influence careprovider perceptions is money. People exposed to money are more likely to believe social advantaged groups should dominate disadvantaged groups and that victims deserve their fates.

We provide below examples of institutional context and behaviours that support and defend the dehumanisation of pregnant and birthing women by omission. In all of the cases described below, NGOs were the only ones monitoring and raising concerns about the blatant displays of discriminatory and disrespectful attitudes towards women. States were reluctant to take action unless there was sufficient public response or media attention. In most of the cases outlined below, limited or no sanctions and certainly no training was introduced to address the attitudes of careproviders. In every one of these examples, the reaction was defensive, resistant to change, arrogant and dismissive of the impact it was having on women.

Spain



In 2011, the Spanish Society of Gynaecology & Obstetrics (SEGO) published a series of cartoons in their newsletter depicting seriously disparaging and disrespectful images of women as the centre of their jokes. Amongst other things, old women with protruding uteri, doctors with scissors ready to turn a child into a girl, interactions with unsanitary prostitutes,

women dressed as prostitutes portrayed as stupid and jokes about female urinary incontinence. Despite several complaints, no apology ensued. Then president of SEGO, José María Lailla, defended the content, saying that it was humor for the men, and that the society had more important things with which to concern itself than the women complaining.⁶²

Canada

“OB/Gyne Style by Sunnybrook Residents”

<https://youtu.be/8hGfBDABphQ>

This is a You Tube Video initially posted by University of Toronto and Sunnybrook Hospital residents, called “OB/Gyne Style”, which was later removed following complaints by women and the NGO Humanize Birth.

In the video, a young male resident, flanked by obstetric nurses wearing high heeled boots and gyrating to music, performs a song to describe his “typical” experiences in the Labour Ward at the hospital, to the tune of a Korean pop-song called “Gangnam Style”. In every scene, the birthing woman (initially, a faceless woman of colour or a doll of a coloured woman) is seen lying restrained on her back in stirrups, with her legs spread as widely as possible and the male doctor positioned between her legs, repeatedly pointing and looking at her vagina. As the focus is entirely on her vagina, there is no effort to make eye contact (in fact all the staff in her presence are wearing sunglasses) or staff are seen staring at a plastic baby’s crowning head. The obstetric nurses stand behind doctor and pretend to perform various medical procedures. Lyrics deployed in the cover song suggest that the women’s bodies start behaving “properly” when the hero doctor arrives and that, under his watch, there are no falling CTG scans. He asserts himself as the producer of babies.

The Vice President of communications at Sunnybrook, Craig Duhamel, said he couldn’t understand what all the fuss was about from women’s groups. Although the hospital eventually took the video down, medical professionals in Canada insisted that their right to freedom of speech prevailed and posted the same video on their personal accounts.

Sunnybrook Hospital and its residents’ hostile and aggressive reactions to women’s complaints do not come as a surprise to NGOs who have been advocating for women’s rights in childbirth. Contrary to the assertions of professional Medical Associations and individual

⁶² Alvarez, J. “Igualdad pide a la Sociedad de Ginecología que retire unas viñetas ‘denigrantes’” (2011) El Mundo (21 Sept) <<https://www.elmundo.es/elmundo/2011/09/21/espana/1316622429.html>>.

medical professionals, misogyny (and the resulting confusion of facility based medical and midwifery personnel who have been systemically trained to perpetuate this misogyny) is more common than not. As noted by Mr Duhamel, in his opinion, all of the medical professionals who watched the video, enjoyed it and that was good enough for him.

United States of America

In 2016, Dr Kathryn Morrison (OBGyn) wrote a passionate letter to the *New York Times* in response to an article about maternal mortality in the USA, which was not published, but later picked up by the *The Buffalo News*:

"Your editorial passed over the real reason behind the unconscionable rise in deaths among childbearing women in the United States—American obstetric practices. As a Board Certified Obstetrician-Gynecologist, I see first hand that pregnant women are subjected to multiple unscientific physician and hospital protocols...All of this despite copious scientific evidence that it does not help babies, but harms their mothers, has led to an insane cesarean section rate and the increasing maternal death rate and 'near misses' (i.e. women that don't die but come close)."

Kathryn Morrison MD, OBGYN New York⁶³

Dr Morrison listed the dangerous common practices in her letter, such as:

- (a) routine inductions (inductions that take place prior to 42 completed weeks);
- (b) the use of continuous electronic fetal monitoring to replace attendants;
- (c) refusal or failure to offer food and drink in labor;
- (d) drugs and procedures to speed up labor, which include keeping women restrained and in supine positions;
- (e) vaginal birth after cesarean (VBAC) policies that discourage or deny women the right to a vaginal birth altogether."

⁶³ Bregel, S "How Doctors Cross the Line in the Delivery Room: The struggle to maintain bodily autonomy—rights to our own bodies during childbirth—is real." (2017) Vice News (14 Jan)
<https://www.vice.com/en_us/article/aevxxk/how-doctors-cross-the-line-in-the-delivery-room>

It should be noted that current efforts to stem maternal mortality in the USA suggest INCREASED interventions as opposed to addressing the systemic causes linked to racial profiling and discrimination and excessive of non-evidence based practices.

Guatemala

https://twitter.com/Dandoaluz?ref_src=twsrc%5Etfw%7Ctwcamp%5Etweetembed%7Ctwterm%5E1080314475524296704&ref_url=https%3A%2F%2Fwww.bebesymas.com%2Fnoticias%2Fimperdonable-vergonzoso-parto-primer-bebe-2019-guatemala

The twitter feed of NGO Dandoaluz pins a video taken of a birth in a Guatemalan hospital in anticipation of celebrating the new year in 2019. A crowded hospital birthing room, full of healthcare personnel wearing party props, loudly shouting a countdown, with the infant held out of sight so as to coincide apparent birth with the New Year, while the mother is visibly suffering, eyes closed and lying on her back, shivering. When the countdown finishes the baby is rapidly pulled out amongst a crowd of hospital staff celebrating the New Year. No one looks at, talks to or supports the mother. The new year celebration took priority over the dignity and welfare of the mother and her newborn. Hospital personnel appeared oblivious to the violation of a mother's right to privacy, or right to the highest attainable level of health, including preventable suffering. The recording and dissemination of this video by those who were responsible for protecting her dignity, privacy and health, is a blatant example of the disconnection and disregard of pregnant women's human rights in a context where health care personnel operate with complete impunity.

United Kingdom

Sareena Ali, a young student from Pakistan expecting her first child died shortly after another woman had died in the then largest NHS maternity unit in the country. Sareena was on life support and her condition was not disclosed to investigators until after the death. Her husband, Usman said he was concerned asked for help - three times.

"They were treating me like an animal. When I asked if anyone was going to be seeing her, they said they were about to change shifts."

Sareena's eyes were rolling back in her head but the midwife who finally checked on her said that she was *"a drama queen and suggested that Sareena have a shower."*

As Sareena was dying from uterine rupture, Usman begged the midwives to attend and they refused. When the emergency team finally arrived and placed an oxygen mask on Sareena's face, Usman had to point out that the mask was not connected to the oxygen. The medical team conducted an emergency caesarean, but because there was no equipment for the baby,

someone had to run with her to the nearest special baby unit. The baby was already dead. Usman said that his wife and baby were victims of systemic racism.⁶⁴

Venezuela



In 2015, student obstetrician Daniel Sanchez posted this image with the caption "*Lady I can deliver your baby but first let me take a selfie,*" on his Instagram page. The woman's naked body and private parts are exposed while she lies in a submissive supine position and, again, is faceless. She is surrounded by fully dressed, seemingly expert, uninformed personnel, one of whom still inserting his fingers into her vagina. Sanchez goes on to assert that his team can "*bring kids into the world and reconstruct pussies*", that their skills are such that women can look forward to being "*brand new, like a car with zero kilometers on the clock.*"

When NGO Roses Revolution complained, Sanchez apologized for any offense but sought to absolve responsibility by denying taking the picture himself. He then claimed the woman in question is respected because "*you cannot see her genitals or her face*". He also claims he is one of the most empathetic students on the team and that women often request that he

⁶⁴ Manzoor, S "My wife and baby died in labour" (2011) The Guardian (10 Sept), <<https://www.theguardian.com/lifeandstyle/2011/sep/10/usman-javed-wife-baby-died-hospital>>

specifically perform their vaginal examinations, because he is, in their view, the most gentle. He appears to be unaware that he has reduced the woman to a reproductive torso.

Argentina

“A Baptism and Selfies During a C-Section”

<https://www.youtube.com/watch?v=T-QYYDhFbE>

In October 2018, a doctor on her first year of medical practice in an Argentinian hospital, recorded the surgery as her “baptism” as she performed her first cesarean surgery. The baptism involved throwing saline solution on her nape while she was performing major abdominal surgery on a pregnant woman. She subsequently posted the “celebration” on her social media links where it went viral and prompted a series of complaints. The reaction of the hospital, which is recorded on the You Tube video, consists of:

- (a) denying the obvious violation of the woman’s right to privacy, dignity and respect;
- (b) asserting that the saline solution was safe and that the mother tacitly consented even though no one had asked her beforehand if the baptism or the recording could take place, or consulted with her after the video had gone public and caused a sensation.

(b) Violation of the Human Right to Informed Consent and the Right to Refuse Treatment

The human right to informed consent is based on the right to bodily autonomy and bodily integrity. Every woman, pregnant or otherwise, has the right to information which allows her to make choices and to informed consent in the provision of any treatment in maternity healthcare, including from private providers of healthcare.

Article 1 of the Universal Declaration of Human Rights requires every person to be treated with dignity and equality before the law.

Articles 7 and 9 of the [International Convention on Civil and Political Rights](#) preserves the human right to liberty and the right not to be subject to cruel, inhuman or degrading treatment.

Article 5 of the [European Convention on Human Rights and Biomedicine](#) 1997 provides:

“An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time.”

Human Rights in Childbirth has observed, in relation to our work around the globe, that there is very little respect for, or observation of, womens’ rights to informed consent and the consequent right to refuse medical treatment. Pregnant women are entitled to be treated with dignity and equality. This right is not being protected in maternity healthcare facilities.

Since 2013, HRiC has received the reports of rights violations from around the globe, including violations of the fundamental rights to self-determination, autonomy, freedom from discrimination and informed consent, and the right not to be subjected to cruel and inhuman treatment. In addition, we have consulted, worked with and advocated for grassroots organisations who provide HRiC with reports around the globe. The reports consistently refer to the following concerns:

1. “Bait & Switch”

Misrepresentation or concealment of the health care provider’s or the facility’s intentions, practice and preference, in order to gain women’s trust and custom during the course of the pregnancy. Careproviders then impose a highly interventionist model during the last weeks of pregnancy, when it is often too late, and difficult, to change provider. This practice is aided by States refusing to mandate that facilities and careproviders disclose their intervention rates.

USA

The following report on Ms Rinat Dray is not the first case of forced medical treatment in childbirth in the USA and it will not be the last. Ms Dray’s representatives, the National Advocates for Pregnant Women, have dealt with several such cases.

In 2018, Ms. Dray attended Staten Island University Hospital to deliver her third child. For personal and religious reasons, she actively pursued a VBAC in her search for a careprovider and the hospital she finally choose, Statten Island NY, promised to support her in achieving this. When she arrived at hospital, however, another doctor

on duty decided that Ms Dray would have a Cesarean Section. When Ms Dray exercised her right to medical decision-making and refused cesarean surgery, the hospital simply overruled her.

Her physician wrote in her medical records: "The woman has decisional capacity. I have decided to override her refusal to have a c-section." Following a secret hospital policy that purports to authorize doctors to subject pregnant women to forced surgery and to do so without a court order, doctors operated on Ms. Dray. The policy said:

“Every reasonable effort shall be made to respect the rights and wishes of the woman, but also to protect the welfare of the fetus.

Because of the physiologic dependence of the fetus on the pregnant woman, the burden of consequences of her actions on the fetus should be taken into account by her doctors and staff.

In some circumstances, the significance of the potential benefits to the fetus of medically indicated treatment may justify using the means necessary to override a maternal refusal of the treatment.”⁶⁵

Indonesia

“The hospitals will all tell you that you can come in for a water birth, but when you get there, it is a room that is being used for storage only. Nearly all of my friends have had many repeat Cesarean sections. We all have friends who have died in childbirth, usually after the third or fourth Cesarean section. Abortion and birth control is not legal in Indonesia.” - Eka Maya, MW

Australia / UK/ Canada

HRiC regularly receives reports from women in these countries who complaint that careproviders fraudulently agree to support their birth plan at the time of engagement, only to discover, on arrival at hospital, that the birth plan has either

⁶⁵ Redden, M. “New York hospital's secret policy led to woman being given C-section against her will: The Staten Island University hospital offered doctors instructions for performing procedures without a pregnant woman’s consent” (2017) The Guardian (5 October), <<https://www.theguardian.com/us-news/2017/oct/05/new-york-staten-island-university-hospital-c-section-ethics-medicine>>

been “misplaced” or that the person who agreed to support the birth plan “cannot be found”.⁶⁶

India

Just prior to the Human Rights in Childbirth Conference, Mumbai in February 2017, HRiC and our partner organisation Birth India launched and promoted a petition requesting that hospitals disclose their Cesarean Section rates in India. Within a week, the petition had attracted approximately 250,000 signatures, and now stands at 369,514 signatures. The comments attached to the signatures were illuminating. Women described being regularly misled into attending facilities which promised normal birth, water birth or gentle birth, only to find themselves in a highly interventionist medical structure in which they were restrained to a bed, subjected to treatment without disclosure and terrorised into having an “emergency C-section”. Petitioner Ms Subharna Ghosh, who drafted the petition and led the initiative wrote:

Caesarean deliveries have become a business. The hospitals and doctors are making money off unsuspecting women and pushing them towards surgical deliveries.

Even though serious complications were not detected, I was cut open to deliver my baby. I wanted to have a natural birth but had to undergo a C-section as it was presented to be more 'scientific, modern and risk-free'. I was misled, manipulated, confused and my choice was overridden. For many of us, the right to informed-refusal or consent during childbirth is hardly an option either due to lack of awareness or the high-handed attitude of doctors.

It was a long, painful, depressing recovery for me and when I looked into this issue, what I found was alarming.⁶⁷

Despite initial assurances from the government, there has been no legislative or administrative response to Ms Ghosh’s petition or request. The Cesarean Section rates in India continue to rise at an astonishing rate, including in the poorest regions in

⁶⁶ Dahlen, HG & Hazard, B “Dont throw the birth plan out with the bath water!” (2016) The Ethics Centre (2 Aug) <https://www.westernsydney.edu.au/nursingandmidwifery/home/news-and-events/news_stories_and_event_list/dont_throw_the_birth_plan_out_with_the_bath_water!>.

⁶⁷ Ghosh, S “Make it Mandatory for All Hospitals to Declare the Number of Cesarean Deliveries” at <<https://www.change.org/p/make-it-mandatory-for-all-hospitals-to-declare-number-of-caesarean-deliveries-safebirth>>.

India where there is limited follow up or acute care options in the event of complications.⁶⁸

Argentina

During the birth of her first baby, Agustina Petrella was a victim of Obstetric Violence in an Argentinian health care facility. In 2014, when she was pregnant with her second child, she chose an expensive private obstetric clinic in Buenos Aires, carefully selected a birth team and provided the hospital staff with a Birth Plan detailing low lighting and privacy during labor, immediate skin-to-skin contact right after birth should the baby be healthy and breathing on its own, that the baby not be washed or vaccinated immediately after birth, and exclusive breastfeeding. When Agustina was 39 weeks pregnant, the hospital's Head of Neonatology called her to let her know that while they knew the law, they "*didn't do respected births*" and that she may be separated from her baby for 8 hours should there not be private rooms available at the time of delivery. "*I was terrorized, for them it was more important their own rules and comfort than the human rights of my daughter*" Agustina recalls. At 42 weeks of gestation, a cesarean section was decided and Agustina's fears were confirmed. There was no private room available the day she gave birth. "*They were going to separate us, there was nothing I could do about it. I felt imprisoned*" While preparing her for surgery, her doctors joked about not having done a cesarean section before. When the baby was born, there was no skin-to-skin contact. An hour after the birth, Agustina was allowed to see her baby, who was sleeping, washed, vaccinated and aspirated as well as formula fed. "*All the contrary to what I asked for*".

The next day, Agustina went to the nursery to reclaim her baby so that she could breastfeed her. She saw that babies were left alone crying, some of them naked, in their cribs. Agustina was visibly anguished so facility personnel reluctantly agreed for her to take her daughter. Hours later, a doctor she didn't know entered Agustina's room and said:

"We know who you are, because here we are all very united, you are the one who presented the letter. We are not here to fulfill the whims of the parents".

⁶⁸ Pacha, A "India might soon have the most Cesarean rates" (2019) The Hindu (6 April), <<https://www.thehindu.com/sci-tech/science/india-might-soon-have-the-most-caesarean-births/article26756931.ece>>

Augustina's husband was asked to leave the room, for no apparent reason, so he refused. The doctor - a female doctor - demanded that Augustina return her baby to the nursery, and threatened to report her to child services if she did not comply. Augustina recalls that the doctor also suggested that she would tell a judge that Augustina refused to have the baby medically checked after the birth, as evidence of potential child neglect. Augustina's obstetrician discharged her earlier than medically recommended time, claiming he did so "*because of how things went*".

Italy

Illaria Dal Sasso was 31 and pregnant for the first time. She had an uneventful pregnancy and was an obedient patient. Prior to her birth, she attended the public hospital and talked to the staff about having an active birth. Facility personnel assured her that her wishes would be honoured.

Her actual experience, on arrival at hospital, was markedly different. Ilaria's waters broke and the doctor advised that her birth was imminent. She was then escorted to a labour room, attached to a monitoring machine, strapped down and left alone in the dark without even so much as a glass of water. She finally requests an epidural and is told that it is too late. While Ilaria is trying to push, the doctor performs an episiotomy without warning. "*It is not true that the episiotomy during the contraction does not hurt,*" says Ilaria. "*The pain is atrocious and it is like cutting live meat*". Later, Illaria recalls a giant man entering the room and, without any warning, performs the Kristeller's maneuver on her abdomen in order to expedite the birth. Illaria and her husband protest, but they are ignored and the baby is finally born. Illaria holds her baby for a moment before the baby is whisked away. Staff then proceed to use the Kristeller Manouever to attempt to expel the placenta. While Illaria is still recovering from that, the midwife proceeds to stitch her perineum without pain relief. Illaria begs for anaesthetic and is told that the facility has run out. She does not see her baby for several hours. The stitches are poorly done and have to be removed a week later.⁶⁹

⁶⁹ Ditta, D "Tagli vaginali senza preavviso e trattamenti violenti: così il mio parto si è trasformato in un trauma" (2019) TPI News (18 Apr), <<https://www.tpi.it/2017/09/20/violenza-ostetrica-donne-italia-testimonianza/>>

2. Maternal Grooming

Maternal grooming refers to the way in which women's expectations of having a safe and respectful birth is altered through doctor-woman discussions that take place either in antenatal visits or in birth settings. Careproviders use these sessions to redefine "safety" in accordance with institutional preferences, not women's human rights. For women who experience these discussions, they are best described as a form of strained interactions where careproviders repeatedly profile everything that is "abnormal" about the woman's body. Through this focus on *potential* contraindications in pregnancy, tests are imposed without explanation, including additional and unnecessary testing such as repeat late term ultrasounds, and discussions are driven around why those maternal imperfections and abnormalities will lead to greater birth interventions or an inability to delivery without interference. The profiling appears designed to instil a form of gendered shaming⁷⁰ and is influenced by country and provider preference. In Europe, UK, Australia, Canada and the USA, women are discriminatorily screened and advised against attempting to deliver naturally for being too fat.⁷¹ Maternal age is also regularly discussed as a means of managing women's birth options.⁷² The information provided is misleading about health care options and/or misrepresents the mother or the fetus' actual health condition in order to obtain "consent" for medical procedures.

A crucial component of maternal grooming, particularly in private health facilities across the globe, is the practice of underplaying the significance of Cesarean section as a major surgical procedure. Cesarean section is often and casually presented in antenatal visits as a quick, convenient, clean, painless and modern procedure to women and their partners. Many women report feeling shocked and overwhelmed by the seriousness, and the impact, of Cesarean section surgery on them. No one has

⁷⁰ COHEN SHABOT, S & KOREM, K "Domesticating Bodies: The Role of Shame in Obstetric Violence" *Hypatia* vol. 33, no. 3 (Summer 2018).

⁷¹ Denize et al. (2018), Addressing cultural, racial and ethnic discrepancies in guideline discordant gestational weight gain: a systematic review and meta-analysis. *PeerJ* 6:e5407; DOI 10.7717/peerj.5407; Saxena I, Kumar M, "Obesity discrimination in healthcare" *Eur J Intern Med.* 2017 Dec;46:e29-e30. doi:

10.1016/j.ejim.2017.09.006. Epub 2017 Sep 12.; Mulherin K, Miller YD, Barlow FK, Diedrichs PC, Thompson R., "Weight stigma in maternity care: women's experiences and care providers' attitudes." *BMC Pregnancy Childbirth.* 2013 Jan 22;13:19. doi: 10.1186/1471-2393-13-19; Snyder, B "Fat Shaming the Pregnant: How the Medical Community Fails Overweight Moms" (2018) *The Huffington Post* (5 Sept)

<<https://www.huffingtonpost.com/author/brianna-snyder>>

⁷² Kydd A, Fleming A "Ageism and age discrimination in health care: Fact or fiction? A narrative review of the literature." *Maturitas.* 2015 Aug;81(4):432-8. doi: 10.1016/j.maturitas.2015.05.002. Epub 2015 May 18.

reported being informed that a Cesarean section involves major surgery or cutting through several layers of muscle and tissue. None of the women HRiC representatives have spoken with were ever advised of the small but significant risk of stillbirth or placenta previa in future pregnancies following Cesarean section⁷³, the short and long terms health risks to infants⁷⁴, or the higher risk of maternal mortality.⁷⁵

Women who seek continuity of carer, even at significant personal cost, are not informed about their choices in childbirth. Across the globe, medical careproviders have refused, *even when asked directly*, to disclose their intervention rates or discretions in relation to hospital policies. In particular, younger medical professionals do not disclose the restrictions on their practice such as professional or insurance restrictions that impact on their intrapartum practice, *even when this information is specially requested*.

Maternal grooming does not end with the birth. It involves a post-natal process of gaslighting women into believing that they were responsible for the interpersonal conflict or the abuse because of failure to comply or because their bodies fail them. Curiously, some of the typical responses women receive when they complain or report their experiences, are often the same regardless of country - suggesting that facility personnel attitudes and context driving abuse and disrespect stems from the education and training that personnel are receiving. These include:

- (a) You should be happy, I/we/he saved your life!
- (b) You have a healthy baby, that's all that matters;
- (c) This is what childbirth is like, you'll get used to it;
- (d) Its time to grow up and think of your family - you have a baby to take care of now;
- (e) I am sorry that happened to you, I will ask the head nurse to look into it;

⁷³ Kenny L etal, "Cesarean section and rate of subsequent stillbirth, miscarriage, and ectopic pregnancy: a danish register-based cohort study" PLOS Medicine, published online 1 July 2014.

⁷⁴ Peters LL, Thornton C, de Jonge A, RM, Khashan A, Tracy M, Downe S, Feijen-de Jong EI, Dahlen HG, "The effect of medical and operative birth interventions on child health outcomes in the first 28 days and up to 5 years of age: A linked data population-based cohort study" Birth. 2018;45:347–357, DOI: 10.1111/birt.12348.

⁷⁵ Athanasios F. Kallianidisa,*, Joke M. Schutteb, Jos van Roosmalena,c, Thomas van den Akkera, On behalf of the Maternal Mortality and Severe Morbidity Audit Committee of the Netherlands Society of Obstetrics and Gynecology, "Maternal mortality after cesarean section in the Netherlands" (2018) European Journal of Obstetrics & Gynecology and Reproductive Biology 229 (2018) 148–152.

- (f) No, no one has raised these issues with us, most women are very happy with their experience at our hospital.

The gaslighting and dismissing of women's complaints appear to serve a dual purpose of both deflecting the complaints, and distracting the women by using feminised disciplinary discourses to pull them into line. They are reminded that their responsibilities, as good mothers, is to ignore and endure abuse and disrespect for the sake of their children. This is virtually identical to the discourse used to justify staying with a domestic violence abuse.

Some further examples:

Argentina

[an OB to his first time pregnant *patient*, in Argentina] "*Normal birth nah, women pisses and shits on, it's disgusting, let's go ahead and schedule a cesarean.*"⁷⁶

India

"*Women have a tendency to leak from all these various orifices. At least a C-section is clean and sterile - so much better for the baby. It's such a small low cut, you will barely notice it afterwards. I can even do it on an auspicious day for you.*" - Prof Ob/Gyn to family

"*The majority of women in India no longer squat down to wash clothes or perform the household duties like they used to, so they are not able to birth vaginally anymore, particularly the wealthier or educated women. If they insist [on a vaginal delivery], we try to help them with a dual episiotomy - on both sides so the baby can come out faster.*" - Dr (Telangana)

Australia

"*The doctors seem to just tell women that they are either too fat, too old or just asking for it. Then they just keep repeating it until the women believe them and give in.*"⁷⁷
- Prof M/W

⁷⁶ From the birth story that a woman told in person to one of HRiC Board Members.

⁷⁷ Dahlen, HG & Kruske S, "Forget too posh to push, doctors are behind the rise in C-sections" (2012) The Conversation (20 Jan) <<https://theconversation.com/forget-too-posh-to-push-doctors-are-behind-the-rise-in-c-sections-4986>>.

First line interviews with 13 migrant women:

“For instance, some women were told during pregnancy that their pelvis might be too small (although this can only be ascertained through a vaginal birth attempt), or that their babies might be too big or that their baby was in the “wrong” position. Others were given a percentage of possibility for normal birth (i.e. Sally was told ‘you have a 70% chance of delivering vaginally’, presumably as the national c-section average in Australia is 30%). Sandra, pregnant with her third child and planning for her third caesarean, had been seeing the same obstetrician for eight years; her story demonstrates how confidence in birth can be subtly eroded. Her first pregnancy resulted in an emergency c-section for ‘failure to progress’ due to her baby being too “big” for her pelvis. She had considered a vaginal birth after caesarean (VBAC) for her second baby but was constantly put off by her obstetrician who told her her pelvis was probably too small, that she probably only had a 3% chance of ‘delivering’ vaginally, that “I had too much amniotic fluid, I was getting too big, too quick. I was getting all kinds of things ...” Sandra was finally told at 38 weeks to have an elective c-section because her baby was breech. However when the baby was pulled out at the c-section, it turned out he wasn’t breech after all. It was apparent from the interviews with Sandra that she now had little faith in her own body; she was disappointed with not being able to birth vaginally, especially as she’d been so fit and healthy prior to birth”⁷⁸ - Campo

“I was young, healthy and I didnt drink or smoke. I felt great. My obstetrician didn’t share my confidence. She seemed able, in the brief 15 minutes that she spent with me every few weeks, to anticipate or burden me with information about everything that could possibly go wrong with the pregnancy. I am sure she thought she was being very thorough, but there was really nothing wrong with me and I knew that. I began to leave every appointment with this growing anxiety, worrying about whether I would even make it through the pregnancy, yet utterly ignorant of what I could do to help myself or improve my circumstances. As the frequency of the visits increased, so too the anxiety. I was weighed at every visit to see if I was too fat, or too thin or possibly diabetic. I was told to do a battery of tests without any discussion of their purpose. When I asked about them, I was told that we would discuss the results if a problem arose. And she looked hard for problems, even where they didn’t exist. She was particularly concerned with the size of my feet and my height, my husband’s size

⁷⁸ Campo, note 9.

and weight, but she didn't explain why until after my baby was born. We never talked about my birthing preferences or plans. When I asked about labour and birth, I was told it all depended on how I coped with labour, but she actively avoided any open discussion about what was involved. She suggested I attend the hospital birthing classes but warned that they placed too much emphasis on natural birth. In the last 6 weeks of the pregnancy, I received constant comments about the small size of my feet and its possible correlation with my pelvis, the large size of the baby's head, concern that the baby's head had not engaged because first babies "nearly always engage before labour", followed by comments that I may be unlikely to go into labour "in time" or at all." - B.K.

Malaysia

A healthy 27 year old first time mother, reports:

"I was told that it looks in the ultrasound as if I had a fibroid near the cervix and the obstetrician was worried about risking a natural birth. I never saw the ultrasound report. I couldn't believe what was happening, they didn't tell me the surgery was going to be like this. I was taken into the theatre by myself, I was so scared and they said that they had to tie me down in a crucifix position for my own safety. After the surgery, as I just lay there in a daze, they took the baby and left. I was shaking and crying for several hours in that position, but no one came. I thought I was going to die." - SP

Singapore

"Women are just not as physically active as they used to be so they really can't manage the labour anymore or the pain that comes with delivering the baby's head. C-section will be much safer for you. We can even arrange for a small tummy tuck as part of the procedure to make it more worthwhile for the mother." - Dr P

United Kingdom

In the 2013 Birthrights *Dignity Survey*⁷⁹:

- 18% of women did not feel that health professionals listened to them
- 12% of women did not consider that they had consented to medical procedures

⁷⁹ Dignity in Childbirth: e Dignity Survey 2013: Women's and midwives' experiences of dignity in UK maternity care (London, October 2013), <<http://www.birthrights.org.uk/wordpress/wp-content/uploads/2013/10/Birthrights-Dignity-Survey.pdf>>

- 24% of women who had an instrumental birth said they had not consented to procedures

USA

"Being black and on Medicaid should NOT mean we should be bullied into a cesarean. After changing doctors 3 times, Medicaid told me I could not change anymore to find a doctor that would encourage VBAC. At every visit, I was told I was too heavy, not an ideal candidate, and that my baby would probably drown in blood in my uterus. I was constantly being talked over and ignored even in the hospital during labor." - Sabrina

"My first doctor told me, 'Sometimes it just doesn't work,' after he called for a c-section on the failed induction I didn't actually need in the first place. After 6 hours, I had progressed from 0-3 cm, which was deemed not enough progress. My daughter was born at 4:16pm. My private practice doctor was home by 6:00. I was left with the belief that I 'just didn't work right.' My second doctor was with one of the most well-respected practices in town, and when I asked about a VBAC, he gave me a laundry list of things that had to work out just right for him to 'let me' have a trial of labor. If I went into labor before 41 weeks, if he was on call, if I progressed 1 cm an hour without augmentation, and if everything went smoothly -- he would 'let me' VBAC. This perfect storm of if's didn't happen, and my second baby was born via the scheduled c-section I consented to after he said, 'Some women just can't dilate.' - JC

Spain

For those women profiled as resistant to Cesarean delivery, induction is usually offered as a compromise, even when not medically indicated. From the many, many reports we receive, it is evident that women are rarely advised that induction carries a significantly higher risk of having an emergency Cesarean section.⁸⁰ This failure to

⁸⁰ Davey M & King J, "Caesarean section following induction of labour in uncomplicated first births - a population-based cross-sectional analysis of 42,950 births" (2016) *BMC Pregnancy and Childbirth Open Access* <<https://doi.org/10.1186/s12884-016-0869-0>>

disclose the pattern of interventions that result from induction is so common that childbirth educators refer to it as the “Cascade of Interventions”.⁸¹

“A story of a Cascade of Interventions in Asturias, Spain:⁸²

*It was Tuesday. I was 41 + 2 [gestational weeks], I went to a routine control. There, the midwife told me that ‘we had to have this solved by Thursday’, the monitor results came back normal. ...After an ultrasound, they said that they did not see it clearly but that it seemed to be little amniotic fluid, so I had to go in that same afternoon for an induction... [after induction with prostaglandins and a whole night of intense labor], the midwife told me that I only was 1 centimeter dilated. They broke my waters and connected me to the monitors and to an IV... I could not move much because otherwise the monitor would lose the [fetus’] heartbeat... They did vaginal examinations on me quite often... [after several hours] they started me on oxytocin because labor was not progressing ... artificial contractions hurt really bad so I asked for an epidural... I was depressed as things were not moving forward, I was in bed with an IV in my arm, monitors straps on my stomach, and a tube from my collarbone to the base of my back. We were not [baby] and I anymore, **it was the hospital trying to get that out.** [A few hours later the midwife] checked on me, I was 4-5 centimeters dilated, just like the last time... I started to cry... I felt trapped in a dead end...*

In that moment an OB showed up and checked again, she said I was 7 not 4-5 centimeters dilated... they allowed me to have a shower (20 minutes is the time allowed without monitor)... I was in a bad mood... because it was not possible to connect with the midwife. I don’t understand how births are attended by someone you never seen before... I just wanted her to leave me alone, to stop telling me stories and doing vaginal examinations all the time... I needed to focus... When they did not puncture me, a whistle would sound, the matron or the nurse would come back, they

⁸¹ Sally K. Tracy, Elizabeth Sullivan, Yueping Alex Wang, Deborah Black, Mark Tracy, Birth outcomes associated with interventions in labour amongst low risk women: A population-based study, *Women and Birth*, Volume 20, Issue 2, 2007, Pages 41-48, ISSN 1871-5192 <

<https://doi.org/10.1016/j.wombi.2007.03.005>>; Tracy, S. K. and Tracy, M. B. (2003), Costing the cascade: estimating the cost of increased obstetric intervention in childbirth using population data. *BJOG: An International Journal of Obstetrics & Gynaecology*, 110: 717-724. doi:10.1111/j.1471-0528.2003.02045.x.

⁸² Anonymous story, “305. Nacimiento de N., Hospital Álvarez Buylla (Mieres). Julio 2012.”, elpartoesnuestro.com, Available online at https://www.elpartoesnuestro.es/relatos/nacimiento-de-n-hospital-alvarez-buylla-mieres-julio-2012?field_centro_value=&category%5B%5D=3&field_story_tax_tid%5B%5D=728&sort_by=field_count_value&sort_order=ASC. HRiC translation from Spanish.

would tell me not to move... Finally, when I felt like pushing they told me not to... they put me in the 'push, push' position, lying in bed on my back... The midwife congratulated me, she said that I pushed very well ... Finally good news.

Then the OB came and the midwife asked me to push so that the OB could see. I felt like a student who was asked to demonstrate to someone. I don't know what happened but I didn't push so well... When I was 10 centimeters dilated, I was transferred to the delivery room. There I was, in lithotomy with four people around me telling me 'push push'.. **.If I ever had to describe the delivery I did not want to have, I probably would have described something like this.** Although I know it could have been much worse, of course ...I pushed hard... Then they told me that [the baby] not only was not descending, it was going backwards, I do not know why they did not put me upright. They made me the Kristeller maneuver. ... Everything in me was pain. I could hardly speak, I asked for water sticking out my tongue. I did not understand how nobody could realize that what I wanted was water... I started getting dizzy... The midwife next to me commented ... how badly I was pushing. At one point **the OB asked me if I wanted to give up** ... but I resisted... they told me it had to be a long push so I pushed even when the contraction passed. I wasted a lot of energy because of that ... I was reluctant to believe that the thing was going to end as it seemed it was going to end, ... with that tremendous frustration, I ended up accepting the cesarean section....

I heard [the baby] cry, but what I wanted was to see him. They told me that the pediatrician was to see him first, then they showed it to the father and then they took him to the nursery ... I got pissed off. I knew how important skin-to-skin contact was at birth... [I fell asleep] when I woke up, they told me they knocked me down for awhile... I felt guilty and anxious... When they brought me to my room, I saw [husband] doing skin-to-skin with [baby], I cried... the nurse made a comment about my hormonal status and left... I feel a tremendous rage because I am convinced that **it could have been an incredible experience if our rhythms had been respected.** But this society is like that, it makes you hurry up even to be born..."

3. Mandating routine interventions without prior disclosure

A common, if not universal, theme across all maternity health systems, is the practice of never disclosing hospital policies that mandate routine interventions and invasive procedures at a facility to families⁸³, including but not limited to:

- a. mandatory periodic vaginal examinations, CTG scans, blood tests for drug and alcohol screening and pitocin induction of labour;
- b. prioritising the fetus over the woman;
- c. denial of access to a support person of the woman's choosing;
- d. prior consent, on arrival at hospital, to all forms of intervention at the careprovider's discretion and without explanation;
- e. placing women in the supine position for the convenience of the doctor;
- f. strict observation of reduced time limits for stages of labour;
- g. routine episiotomy, Kristeller Maneuver and the application of "the husband stitch"⁸⁴, all without consent;
- h. denying food and water for women profiled as most likely to have a Cesarean-section;
- i. expedited cord-clamping and cutting;
- j. removing the newborn to expedite management of delivery of the placenta;
- k. denying mother and baby skin to skin contact immediately after or in the first few hours of birth;
- l. feeding the newborn formula in order to increase out of pocket charges on the family;
- m. refusing to release mother or infant until all fees have been paid;
- n. VBAC bans, twin vaginal delivery bans and breech vaginal delivery bans;
- o. symphysiotomies, or more recently, "natural symphysiotomies".

The mandating of procedures and the failure to disclose them prior to the provision of service, is of itself, a breach of the civil and trade practices laws of most countries, in addition to human rights violations. This practice is, in effect, state endorsed violations of the civil law, managed by a blanket denial of their very existence unless

⁸³ Thompson R & Miller YD, "Birth control: to what extent do women report being informed and involved in decisions about pregnancy and birth procedures?" (2014) BMC Pregnancy and Childbirth 14, 14:62 <http://www.biomedcentral.com/1471-2393/14/62>

⁸⁴ Mamabirth, "The Husband Stitch" (2013), viewed 10 May 2019, at <<http://www.mamabirth.com/2013/07/the-husband-stitch.html>>

legal proceedings are commenced. In addition, as noted above, the women who expressly seek assurances are falsely informed that their requests will be met, and human rights protected. These false assurances should also negate any subsequent contract for payment and raise questions of accountability. Despite obvious violations of the law and human rights, however, this practice is virtually universal and is being endorsed by courts of law.⁸⁵

An interesting dynamic HRiC has observed in facilities is the use of gender divisions to manage and implement these undisclosed policies. While a mainly male dominated medical profession maintains a supervisory role during admission and labour, this seemingly “lesser” work is allocated to a largely female dominated midwifery profession. Nurses and midwives primarily responsibility, within facilities, appears to be to administer the undisclosed policies and obtain compliance, whether by bullying, cajoling, pestering, nagging or abusing.⁸⁶ Women who are not aware of hospital policies subsequently perceive midwives as perpetrators of horizontal violence against them, and the doctors as “white knights” coming to save them.⁸⁷ In turn, midwives who seek to defend the human rights of mothers will quickly find themselves at odds with the administration and disciplined accordingly.

The unexpected violation of the most basic and fundamental of the maternal human rights to bodily integrity, privacy and autonomy appears to have a traumatic and dissociative impact on women, many of whom report feeling displaced, bewildered, confused and/or terrified because things have gotten beyond their control. This has a significant and enduring impact on women and their infants, being linked to reduced breastfeeding and higher risk of postpartum depression.⁸⁸

⁸⁵ Dray v. Staten Island Univ. Hosp., No. 500510/2014 (N.Y. Sup. Ct. filed Jan. 22, 2014) <<http://advocatesforpregnantwomen.org/Dray%20final%20amicus%20brief%20signed%20without%20motion%20attached.pdf>>

⁸⁶ Davis DL, Homer CSE. Birthplace as the midwife’s work place: How does place of birth impact on midwives? *Women Birth* (2016), <http://dx.doi.org/10.1016/j.wombi.2016.02.004>

⁸⁷ Filby A, McConville F, Portela A (2016) “What Prevents Quality Midwifery Care? A Systematic Mapping of Barriers in Low and Middle Income Countries from the Provider Perspective.” *PLoS ONE* 11(5): e0153391. doi:10.1371/journal.pone.0153391; Declercq, E., Sakala, C., Corry, M. P., Applebaum, S., & Herrlich, Ariel. (2013). *Listening to Mothers III. Pregnancy and Birth*. New York: Childbirth Connection.

⁸⁸ Kendall-Tackett, K, Cong, Z & Hale T, “Birth Interventions Related to Lower Rates of Exclusive Breastfeeding and Increased Risk of Postpartum Depression in a Large Sample (2015) *Clinical Lactation*, 6(3), <http://dx.doi.org/10.1891/2158-0782.6.3.87>

Elevated socio-economic status and/or engagement with costly private facilities do not appear to alleviate the problem - quite the opposite. Across all countries, increased birth intervention - and increased harm - seems to occur in private facilities.⁸⁹

Croatia

In a survey⁹⁰ conducted by RODA Parents in Action (RODA), based on the analysis of 4081 responses, RODA reported that 81% of women were attached to a CTG monitor for the full duration of their labour and birth, 66% of women had their membranes artificially ruptured, 70% of women had their labour augmented with artificial oxytocin, and 56% of women were subjected to an episiotomy. In addition, 54% of women endured the Kristeller Maneuver; a practice that entails more risks than benefits and is discouraged by the World Health Organization.

Slovakia

In a publication named “WOMEN MOTHERS BODIES”⁹¹ based on the testimonies of mothers who gave birth in Slovakian health facilities, the Slovakian NGO Citizens Democracy and Accountability warned of routinely used interventions such as episiotomy and the Kristeller Maneuver.

Spain

The Spanish Observatory of Obstetric Violence conducting a survey of more than a 1000 women, found that over 50% of women were not informed of the intervention (induction, Kristeller Manouver, episiotomy) before it was performed, in 60.8% of cases, women were not given explanations or reasons for the procedures, and 76.6% of women were not informed about the different options (including the expectant management of labor). A whopping 80.4% of Spanish women were not informed of the potential risks associated with the procedures subjected on them. Regarding birth plans, a quarter of the women who responded to the questionnaire were treated disparagingly for presenting one and in 65.8% of the cases, the birth plan was not

⁸⁹ Dahlen HG, Tracy S, Tracy M, et al” IRates of obstetric intervention and associated perinatal mortality and morbidity among low-risk women giving birth in private and public hospitals in NSW (2000–2008): a linked data population-based cohort study” BMJ Open 2014;4:e004551. doi:10.1136/bmjopen-2013-004551

⁹⁰ Survey on Maternity Practices in Croatia, March 2015 (Available online at http://www.roda.hr/media/attachments/english_rodaroda%20Survey%20Maternity%20Services%20Croatia%202015.pdf)

⁹¹ Available online at http://odz.sk/en/wp-content/uploads/Women-Mothers-Bodies_summ_EN.pdf

respected. Similar results were found by NGOs in Argentina, Italy and Croatia, among other countries.

USA

“As soon as I entered my hospital room the nurse started putting an IV into my arm and I politely explained to her that I want a natural birth and I will not be using any forms of IVs, monitors, or anything confining me to my room so that I could walk the halls. She rudely replied “this is not an option, it's hospital policy” and she went ahead and inserted the IV into my arm. Pitocin was given to me shortly after and I tried arguing that I did not want it because my contractions had already started but again they reminded me that I MUST have it because I was 2 weeks overdue.” - B.S.C

“Only when my labor became quite fast and painful did I ask my husband to check the bag on the IV pole. He discovered that it was a bag of Pitocin, to which I had not consented. When we asked the nursing staff to remove the drug, we were told it was impossible to do so because the OB ordered it.” – D. M. (CO)

“The doctor said, yeah, let's go ahead and add in another stitch so we can make sure this is nice and tight”, he said it to him. Not to me... I was just lying there like a lump”⁹²The “husband stitch”⁹³ consists of putting in an extra stitch, while repairing a tear or episiotomy cut, in the vaginal opening in order to tighten it to allegedly heighten the pleasure of the male sexual partner.

Iran

“Over the last 30 years, medicalised birth models for healthy pregnant women have become the dominant care model in Iran, with the second highest rate of Caesarean Section (CS) in the world, with only Brazil having more. In 2008, the rate of CS was >40% in public hospitals and >90% in private hospitals. Some reports indicate the rate of CS is as high as 80% in some public hospitals in 2009 and 73% in a centre with 5982 annual births in 2014. Lack of a transparent system for public reporting of health information made it impossible to access recent childbirth data in Iran. Policies that have been adopted in Iran's maternity system in the last few decades, has changed

⁹² Murphy C., “The Husband Stitch Isn't Just a Horrifying Childbirth Myth”, 24 January 2018, Healthline.com. <https://www.healthline.com/health-news/husband-stitch-is-not-just-myth#3>

⁹³ Kitzinger, Sheila (1994). *The Year After Childbirth* (1st ed.). Oxford: Oxford University Press. p. 71. ISBN 978-0192177841.

the birth culture dramatically. These policies mainly focused on training medical specialists, while the role of midwives in maternal care has been mostly neglected with maldistribution of personnel (30 obstetricians vs 15 midwives per 1000 births), especially midwives. Due to fee for service model and absence of clear guidelines and transparency at organizational level, obstetricians have gained the power as Andrea Robertson (2006) mentioned in her diary: *Physicians are all-powerful, completely dictating the management of every birth and seemingly oblivious to evidence on care, midwifery skills, the mothers' wishes, or anything else that might impact their practice. These expensive policy changes in the maternity care system have created a fear of normal child-birth among the women and an increased CS rate which is a source of high income for obstetricians. In this system there is no suitable education for pregnant women (midwives are marginalised and obstetricians do not have time to educate women for normal birth), there is lack of support for women (due to shortage of midwifery staff or presence of a family member at birth), mothers and their family's needs are neglected, and human rights do not exist. Therefore, not only the professional but also the women in Iran believe that CS is safer than normal birth and in reality the system serves obstetricians not the women. Although, the need for change in child-birth in Iran is urgent, altering the professional attitude toward birth will not be an easy task, since money is powerful incentive.*" - Dr Maryam Bazargan MD.⁹⁴

4. Global consent to future interventions as a condition of admission

Some women report that, as a condition of admission, they are asked - usually on arrival and in labour - to sign a global consent form which apparently constitutes prior notice and consent to all medical procedures as deemed necessary by the doctor. Interpersonal conflict between family and facility personnel is swift if any questions are asked. Women concede because they are distracted by the labour pains and they feel exposed and afraid of the implications of refusing. This is not consent, let alone informed consent. There are no discussions about the procedures that the woman has consented to before the event. The signature, to the extent that it is at all enforceable at law, is to protect the hospital and its insurers, in the event that careproviders fail to engage with and obtain informed consent from mothers. Most women do not understand that the signature constitutes a significant barrier to accountability in the

⁹⁴ Bazargan, note 11.

event of injury, in circumstances where it is clearly being anticipated by the stronger party at an institution with a culture of practising assault on women.

5. Utilising state enforcement and legal mechanisms to coerce compliance

HRiC has seen a disturbing increase in the willingness of states and the judiciary to intervene on behalf of health facilities to coerce pregnant and labouring women into attending facilities and enduring interventions, including Cesarean section. The practices include:

(a) Prenatal Reporting

The practice of reporting, or threatening to report, mothers to child protection or family services for behaviours that allegedly endanger the unborn fetus, with the aim of separating mother from infant;

(b) Police Reports

Engaging the sheriff or the local police to enter a woman's home, conduct an immediate search and/or forcibly retrieve the pregnant woman for delivery at the facility.

(c) Obtaining Court orders to perform Cesarean sections

Despite oft-repeated statements by superior courts of the dangers of subverting women's bodily autonomy for the sake of the unborn fetus, lower courts in nearly every country, with the support of the state, are conducting bedside trials or ex-parte trials to issue court orders for the arrest and detention of pregnant women.

Spain

As HRiC was preparing this report in early May 2019, we received notice that a pregnant woman in Oviedo, Spain, was being forced to have an induction of labour by court order. The court also authorized a warrant for entry, search and detain of her home. her to hospital to induce labor.⁹⁵

⁹⁵ The woman's lawyer is one of the HRiC Champions 2019. See media coverage of the case here: https://www.abc.es/sociedad/abci-mujer-obligada-hospital-oviedo-necesito-cesarea-201904270233_noticia.html

Brazil

In 2014, Adelir Carmen Lemos de Goés, a national of Brazil, was pregnant with her third child and planned a Vaginal Birth After 2 previous C-sections (VBA2C). She was in labor, when six armed police officers arrived to her home in Torres and took her to hospital, where she was **forcibly sedated and subjected to an unwanted c-section. Both doctors and policemen acted under the authority of a court order** that authorized the several violations of Adelir’s and her baby’s human rights.⁹⁶

Australia

In the state of South Australia, criminal legislation was introduced to prohibit anyone, who is not a registered practitioner, from attending a woman in childbirth. In Nov 2018, a woman reported that her midwife abandoned care at 42 weeks (mandated), just two hours before she went into labour. She did not want to go to hospital without her midwife and refused to leave her room. Her husband called an ambulance, which in turn, called the police. As the baby was born, the police invaded the premises, conducted a search for an unregistered birth attendant, and proceeded to question the mother in her bedroom about her intentions, whilst she was birthing the placenta.

In the state of NSW, until recently the government mandated pre-natal reporting to child protection services. Indigenous women are especially vulnerable to prenatal reporting, which subsequently places them on a CPS “watch”, *and removal at birth with the assistance of law enforcement.*⁹⁷

USA

Reported online to NGO Birth Monopoly:

*“My daughter was medically **kidnapped for five days** following her birth because we declined formula, the eye goop, and he[p] b. They called it neglect”⁹⁸*

⁹⁶ See the media coverage of the case online in portuguese at <https://www.theguardian.com/commentisfree/2014/apr/11/forcing-woman-caesarean-assault-brazilian-embassies-natural-birth> <http://g1.globo.com/rs/rio-grande-do-sul/noticia/2014/04/justica-determina-que-gravida-faca-cesariana-contravontade-no-rs.html>. Source in English available online at

⁹⁷ Hazard, B, “Respectful Maternity Care for Indigenous Mothers” (2017) Aust Midwifery News, Practice Matters, p37.

⁹⁸ From the publicly available Facebook page “Birth Monopoly”, Comment thread to a entry about CPS threats, posted on 16 May 2019. In less than 16 hours, more than 25 women reported CPS threats or actual CPS

“After our second homebirth I refused to let a male OB “examine” me... [for that reason] he called our sheriff and CPS to report child neglect”⁹⁹

*“I was threatened with **CPS for refusing eye ointment for my son....** The nurse was a bully and I ended up accepting the ointment I knew I didn’t want because I was so tired and scared they would take my baby away. She said quote ‘I’m not trying to bully you, but there is a lot of bad gunk down there even if you don’t have any STDs’¹⁰⁰*

*“I was forced into a hospital birth by them **forcibly breaking my water at 36 weeks** when i said i wanted a home birth..then had **my birth plan stripped away little by little..** I was assaulted and mistreated my entire labor and delivery. CPS was threatened over and over b[ecause] i rejected vitamin k and i was bullied until i gave in and allowed them to give it to him. Then when he went jaundice immediately after the shot they tried to bully me into formula feeding.”¹⁰¹*

In 2018, the newborn baby of D.S., a South Carolina single mother in her forties who conceived through IVF, was forcibly removed by child protective services, based on a potential allegation of neglect and endangerment of an unborn. D.S had earlier during the pregnancy refused an “elective” c-section, which was proposed to her based on her ‘advanced’ maternal age. D.S. agreed to attend hospital and remain until spontaneous labor started. She ultimately agreed to a Cesarean section, a few day past her due date. After the surgery, she noticed that a hospital guard had been placed permanently in front of her room. She then discovered that her baby had been removed from her custody and placed in foster care. A pediatrician from the hospital called child services because he suspected mental impairment, based on her initial reluctance to the surgical birth. She eventually recovered her baby’s custody.

Argentina

In March 2019, M.K., a mother of two who was pregnant with her third child decided that she was going to try for a Vaginal Birth After 2 C-sections. Her doctor, who did not agree with her decision, scheduled a Cesarean-section and requested the

involvement in the context of declining medical treatment for them or their newborns. Available online at https://www.facebook.com/search/top/?q=birth%20monopoly&epa=SEARCH_BOX

⁹⁹ Ibid

¹⁰⁰ Ibid

¹⁰¹ Ibid

intervention of the authorities to force her to give birth at his medical institution. A social worker and law enforcement officer attended her home, served a **court order for her** “*to be transferred to hospital by competent staff in order to preserve her life and integrity and that of her pregnancy*”. Her decisional capacity was never in question. She was delivered to the hospital and a Cesarean section was performed on her.

Direct Forms of Abuse and Disrespect

In a facility environment designed to dehumanise, coerce and deceive pregnant and labouring women, it is not at all surprising that facility careproviders:

- (a) exert their power and authority with little appreciation for the impact it is having on labouring women;
- (b) react to perceived challenges to their power and authority with a range of defensive measures, from jokes, verbal abuse, threats, taunts and crude attacks on women’s sexuality, to public shaming and physical abuse;
- (c) engage in punitive measures to discipline ‘misbehaving’ or defiant women;
- (d) perform extremely painful procedures on women without consent or pain relief;
- (e) utilise highly invasive and interventionist procedures without knowledge, consent or any understanding of, or concern for, the impact it has on mothers, such as caesarean-section deliveries and episiotomies, manual revision of women’s uterine cavities without pain relief, inserting long-term birth control mechanisms directly after birth, collective vaginal examinations for training purposes, restraining women to the delivery table, and forced or coerced sterilisations.

These identifiable and tangible forms of direct violence are easy to detect and complain about, but they will prove impossible to address within the current facility based structures of maternity healthcare. Careproviders have been inducted into this system of hierarchy and control for nearly a century and are, in our view, unlikely to relinquish that control, particularly in gender stratified countries. We have extracted below the testimony of women, with special emphasis on those who face added discriminations in facility based care, namely women of colour, women with disabilities, HIV sufferers, members of the LGBTQI community, incarcerated women of a lower socio-economic status and survivors of sexual violence. In the stratification and authority structures of healthcare facilities, women with intersectional concerns are further demoted, in the sub-human scale *by virtue of their added needs*.

(a) Violations of the human right to equality and freedom from discrimination

1. Women of color and the impact of systemic racism

The *intersecting* discriminatory factors impacting people of colour in the provision of maternity care can be life threatening.

Australia

Researchers in Australia conducted a meta-analysis of seventy-six studies across the globe comparing the Caesarean rates between international migrants and non-migrants differed in consistently higher overall caesarean rates for Sub-Saharan African, Somali and South Asian women. The authors could find no evidence to explain the differences in treatment.¹⁰²

“I am a South Indian woman. I was rushed to the nearest hospital during a precipitous labour. When there, I kept trying to stand up, I could feel my baby coming. The staff had different ideas, so after a few tries, they flipped me onto my back, hard, and told me to stay there unless I watched to kill my baby. They then started wheeling me to the theatre. “Wait!” I said, “Why are you moving me?” “Dont worry about it, just sign this form”...When I refused, I was strapped down and my legs put in stirrups. A man was standing over me pointing into my face. “Lets all get a grip here. You need a reality check.” It was the obstetrician and he appeared very angry with me. He crossed his arms as my baby crowned. “Dont cut me,” I said. “Oh dont worry, you are making your own mess down here all for yourself. This is a fourth degree, for sure” he said. I heard my husband shouting - saying he was going to call the police if they didnt let him in to the room. It appears the plan was to put me under general anaesthetic without my consent and perform a Cesarean section. No one factored in that I was educated, knew my rights and had a white husband.” - B.H.

¹⁰² Lisa Merry*, Rhonda Small, Béatrice Blonde, and Anita J Gagnon, “International migration and caesarean birth: a systematic review and meta-analysis” BMC Pregnancy and Childbirth 2013, 13:27 <<http://www.biomedcentral.com/1471-2393/13/27>>

USA

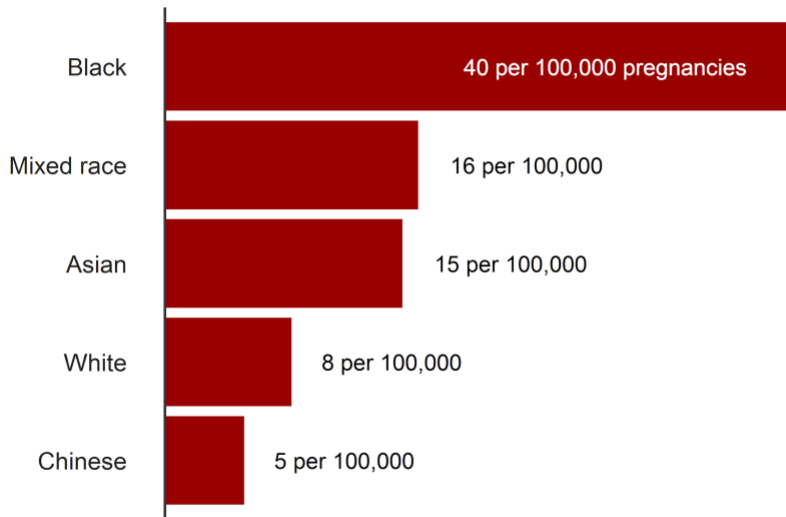
Discriminatory treatment by caregivers in pregnancy and childbirth, is associated with higher maternal mortality rates among African-American women compared to their white peers.¹⁰³

United Kingdom¹⁰⁴

The United Kingdom is also not performing any better. As the figure below shows, the darker the skin tone, the higher the likelihood of a death in childbirth.

Maternal death rates in the UK, 2014 to 2016

Race of women dying during or up to six weeks after pregnancy



Note: Researchers used England figures to calculate UK rates

Source: MBRRACE

BBC

2. Indigenous populations

Indigenous groups, amongst the worst affected by the institutionalised model of maternity care. All around the globe, they are victims of forced sterilizations and healthcare policies that deprive them of their right to give birth in accordance with their cultural beliefs, as well as removing them from their communities in order to give birth

¹⁰³ See for instance, National Partnership for Women and Families, Issue Brief, April 2018 “Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities”. Available online at <http://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html>

¹⁰⁴ Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2018.

in medical facilities, located so far away from their homes that they are forced to be away from their families for days or weeks. The threat of coercion and the removal of their newborns is a serious barrier to accessing care.

Canada

This is the case for indigenous women from Canada, where until the 1970s, many gave birth in their home communities, but since then the centralization of health care resulted in a loss of their traditions in childbirth.¹⁰⁵

New Zealand¹⁰⁶

“New Zealand is a racist country. It has a racist history of oppression against its indigenous peoples; Maori peoples. ...New Zealand’s racist policies and practices that are particularly harmful for Maori women and their children, underpinned by political, socioeconomic and religious bias. This continues to impact on the lives of Māori women and children even today Cram, (1987). These practises have given rise to the degradation of Maori women’s cultural norms, shifted matriarchal roles within their own society, in the form of overt and covert violence. This imposition is constantly and consistently directly manifested by behaviours toward Māori women, embedded in the policy and practice of colonisation that leads to Māori women’s individual demise. This has created an environment which is socially, economically, physically and fundamentally toxic for Māori women as mothers and their pepi and tamariki.

I know case studies where young Maori women have gone into hospital to have their baby, and within an hour of the birth, the State have forcibly, without notice, removed their baby. On one occasion, I as the midwife attended a caesarean section. The woman was under anaesthesia and could not move, when they removed the baby from the theatre and took it away. I did not know this was happening- so not only was the woman confused and angry, but myself as the Maori midwife was also confused and angry. This event happened on 23rd March 2013, and has been going on since. 276 babies were forcibly removed from their mother while giving birth in a New Zealand Maternity hospital. I wrote a letter of complaint to the Maternity Midwifery Advisor, and the CEO

¹⁰⁵ Exner-Pirot, H., B. Norbye and L. Butler (eds.) (2018). Northern and Indigenous Health and Health Care. Saskatoon, Saskatchewan: University of Saskatchewan. Available from: openpress.usask.ca/northernhealthcare. See Chapter 5 by Angela Bowen and Carrie Pratt, “Indigenous Birth”.

¹⁰⁶ Sylvia Pack, Keith Tuffin, Antonia Lyons, “Reducing racism against Māori in Aotearoa New Zealand” (2016) New Zealand Journal of Psychology Vol. 45, No. 3, November 2016

of the Hastings Hospital- (Attached) and received no response. Maori Women are over represented in our jails today. The government has allowed Women serving jail sentences to have a baby, while in prison and keep the baby until 2 yrs of AGE. I AM TOLD THE WOMEN ARE HAND CUFFED TO THE BED, WHEN THEY GIVE BIRTH. I am also aware that when the child turns 2 yrs of age, the state removes the baby from it's mother, and 80% of the babies are then placed in state care with a stranger.” Jean Te Huia, CEO Nga Maia Maori Midwives

3. Immigrant/Refugee Women

Australia

In the State of Victoria, a Sudanese refugee woman was expecting her fifth baby. Despite escaping a war torn region on foot and living and birthing 2 of her 4 children in a refugee camp, she struggled to cope with being in a hospital ward and her labor was progressing. She was very distressed and refusing a Cesarean section. Staff were unable to locate an interpreter, and there was no evidence that they tried. Her eldest son was called to interpret her needs and he merely reiterated her preference not to have a Cesarean section. Unbeknownst to the woman, facility personnel quite put a sedative in her IV drip, placed her under general anaesthetic without her knowledge and performed a Cesarean section against her will. The woman suffocated her infant a few weeks later, at home.

Italy

“they snatched and then amputated my right labia minora. [the caregiver commented:] ‘men do not notice anyways.’ It still hurts...”¹⁰⁷

“[Careprovider to a laboring woman] Hurry up Ms., otherwise we will have have to do a cesarean”¹⁰⁸

¹⁰⁷ A woman's experience in an Italian hospital, extracted from the media campaign #bastatacere Le Donne hanno voce (Break the silence, women have a voice). More than 1000 women told their stories of Obstetric Violence in the context of the campaign launched in 2016 by OVOItalia. See report online at <https://ovoitalia.wordpress.com/2016/06/20/bastatacere-report/>

¹⁰⁸ Ibid

Spain¹⁰⁹

Nancy Narváez, a Paraguayan woman living alone in Spain, was subjected to “forceps training” whereby 4 students were given the opportunity to attempt to extract her baby by forceps without her consent. Nancy was subjected to an episiotomy without consent for the purposes of the training and suffered long term injuries from it. At one point, the tutor screamed “not like that, you could break the baby’s head!” Her baby suffered severe cranial fractures, and internal bleeding to her brain. If NGO El Patro Es Nuestro had not called for an investigation, Nancy’s case would have gone unnoticed as yet another forgotten immigrant statistic.

Mexico

Sandra¹¹⁰, a low income pregnant woman of tzeltall origins, who lives in the Nahá community (in Chiapas, Mexico), sought medical assistance in the closest hospital went she went into labor. She was denied assistance under excuse that the doctors were all on vacation. After insisting at a second hospital, Sandra was admitted, but for the first three hours, she did not receive information about her health status and she received insults by medical personnel. That same day, she underwent a cesarean section and four hours later she was discharged from the hospital. After the birth, Sandra and her husband could not have contact with their daughter and as condition to take their baby they were extorted by the hospital's medical staff, to pay ten thousand pesos, arguing that the newborn did not have medical insurance, even though her parents were insured through social services. For seven days, while trying to get the requested money, the hospital only allowed them to see their daughter through a window, under the argument that the baby girl had a delicate state of health, without explaining what was happening or the seriousness of her condition. On the eighth day, when they returned to visit her, the

¹⁰⁹See <https://www.elpartoesnuestro.es/> at <https://dspace.library.uu.nl/.../Silvia%20Bellon%20Sanchez.GEMMA%20thesis.pdf>.

¹¹⁰ Extracted from the Report “Niñas y Mujeres Sin Justicia, derechos reproductivos en México” by Grupo de Reproducción Elegida (GIRE), México 2015. Available online at <http://informe2015.gire.org.mx/#/inicio>

health personnel announced that their baby had died. They did not received any explanation on the death of their daughter.¹¹¹

4. Survivors of Sexual Violence

USA

Kimberly Turbin told her hospital and birth team that she was a rape survivor and that childbirth might be, as a result, emotionally challenging for her. However, as she was pushing her baby out, in the usual lithotomy position with her legs in stirrups and her genitalia exposed to everyone on the room, her obstetrician announced he was cutting an episiotomy. Kimberly refused loudly and clearly, and asked for an explanation for why he deemed it necessary, and then said “no” again to the procedure. The doctor, irritated by Kimberly’s reaction, not only ignored her refusal, but he went on to cut her vagina and perineum 12 times. Traumatized and physically damaged from the experience, Kimberly decided to seek justice in courts, she consulted approximately eighty (80) lawyers all of whom refused her case (despite having recorded the violation on video) because all they saw was a doctor doing his job.¹¹²

Australia

“Images still haunt me to this day of being “shackled up” to a hospital bed, my legs placed into those awful stirrups whilst I have painful needles inserted into my vagina. I feel could forgive some of the trauma that was inflicted upon me if anybody had only pretended to care about how frightened I was and had talked to me or explained what was happening, instead I was left in a terrified state wondering if my baby would die and what they would do to me next.

The result of the abuse I experienced at this labour ward where my right to privacy (my genitals were at one stage exposed to a whole congregation of male students who were

¹¹¹ See also Murray de López, J. 2019, Maintaining the Flow: competing metaphors of risk and contamination in breastfeeding in Mexico, *Medical Anthropology Quarterly* (impact factor 1.85)
Murray de López, J. 2018, When the Scars Begin to Heal: Narratives of Obstetric Violence in Chiapas, Mexico, *International Journal of Health Governance, Special Edition Maternity Care Governance in a Global Context*23(1), 60-69. doi:10.1108/IJHG-05-2017-0022; Murray de López, J. 2017, Mala leche: interpretación de los riesgos y desafíos médicos de la lactancia materna en la zona urbana de Chiapas (México). *Dilemata International Journal of Ethics*0(25), 121-133; Murray de López, J. 2015, Conflict and Reproductive Health in Urban Chiapas: Disappearing the Partera Empírica, *Anthropology Matters*16(1)

¹¹² K.T. told us her story at the Human Rights in Childbirth U.S. Summit 2016. She eventually found a legal counsel and settled the case.

following a female OB who attended to me, without being asked whether this would be ok with me), informed consent and physical autonomy were taken away from me and where I was in the end treated like a "piece of meat" and not like a human being left me to suffer from PTSD for almost 2 years. Not only did this birth trauma cause me to suffer from nightmares and flashbacks, it almost destroyed my marriage and our young family." - TK

5. Ethnic minority groups

Hungary

The NGO Birth House Association reports a systematic discrimination dynamic for Roma women during pregnancy and childbirth that is directly related to their ethnicity.¹¹³ *'When I was 45 weeks pregnant, I was put in a room in Miskolc where the walls were moldy. And there were only gypsies. At the end of the corridor. They would never come, askin' 'are you OK?', so the doctor wouldn't come to us like he did with the others. When I gave them the money, they put me over to the Hungarians and they gave an appointment for 07:00 the next morning. I'd always say that it is a curse to be a gypsy, I don't know why but somehow we are mistreated much because of that.'* - Ildikó.¹¹⁴

Mexico

[a careprovider to a woman in labor in a mexican hospital] *"... do not cry, hold on, remember when you were doing it, you enjoyed then and now now scream, just hold on..."*¹¹⁵

[during a vaginal examination to a woman in labor in a mexican hospital] *"... the doctor hurt me horribly with his fingers, I moved out, raised my hip and the doctor threwed*

¹¹³ Birth House Association, "The Situation and Possibilities of Roma Women in Maternity Care". Available online at <http://www.szuleteshaz.hu/wp-content/uploads/2016/05/Roma-women-in-maternity-care.pdf>

¹¹⁴ Extract from the Birth House Association report.

¹¹⁵HRiC translation from Spanish. Valdez Santiago R., Salazar Altamirano Y., Rojas Carmona A., Arenas Monreal L.

"Abuse against women in delivery care in public hospitals in Mexico", REVISTA CONAMED // VOL. 21 Suplemento 1, 2016 // PUBLICADO PRIMERO EN LÍNEA // ISSN 2007-932X. Available online at <https://www.medigraphic.com/pdfs/conamed/con-2016/cons161e.pdf>

*my legs and told me to find another doctor because he was not willing to stand my resistance to the examination. He threw my legs to the side and left.”*¹¹⁶

India

“It was my first week as a midwife, working with the community in Bihar. I was standing next to the woman as she lay down. The doctor came over and flipped up her saree over her face and said loudly, “My God, how could any man have got you pregnant with all that hair down there.” Everyone in the room laughed at her. She stayed with her face covered, whimpering in shame.” - K.M.

Mano, a dalit woman from Telengana, said that she was lying on her back trying not to cry out as they stitched up her routine episiotomy cut without pain relief. At times, she would punch the air to cope with the repeated piercing of her very painful ‘region’. At one point, a young male doctor moved in the direction of her arm and she accidentally punched him in the back. He immediately turned and punched her face.¹¹⁷

6. People with disabilities

Croatia

According to a survey on mothers with disabilities in Croatia, *“a worrisome number of those who have children stated that their healthcare providers during pregnancy, birth and in the postpartum period were often uninterested and did not have any knowledge on how to provide support and care to disabled women.”*¹¹⁸

The Ombudswoman for Persons with Disabilities in Croatia has also warned about a lack of information available to pregnant women with disabilities about informed choice because few materials are prepared in a format that they can understand.¹¹⁹

7. Mothers living with HIV

A doula reported that during her work in an university hospital in Central America, women presenting with HIV were told during labor that *“they are trashing the world*

¹¹⁶ Ibid

¹¹⁷ HRiC Conference, Mumbai 2017.

¹¹⁸ Page 66 of the “Mothers With Disabilities Report” by RODA Parents in Action, ISBN 978-953-8131-02-8, Zagreb, rujan 2016. Available online at <http://www.roda.hr/media/attachments/udruga/projekti/ppzird/Majc%CC%8Cinstvo i z%CC%8Cene s inva liditetom.pdf>

¹¹⁹ Communication with the Ombudswoman on Gender Equality with Roda - Parents in Action,, May 2019.

by having children” and jokes were typically and repeatedly made about their sexual and reproductive processes.

“As I was holding the hand of a laboring pregnant woman who was HIV positive, a professor of obstetrics entered the room and said to me

“Are you crazy? Don’t hold her hand, don’t touch her, she’s contaminated!”

I was shocked because the comment came from a professor, someone who knows well that people don’t get HIV through holding hands”¹²⁰

8. Low socio-economic status

HRiC received information that, in at least one country in Central America¹²¹, birthing women in public hospitals are given vertical Cesarean sections, and only those who can afford to give birth in a private facility have access to the horizontal cut *under* their ‘bikini’ line. Low income women being thereby unnecessarily exposed to the higher risk of medical complications, due to the performance of an outdated technique.

India

Five years after the Government of India initiated several interventions to address the issue of maternal mortality, including efforts to improve maternity services and train community health workers, and to give cash incentives to poor women if they delivered in a health facility, a high number of maternal deaths affecting indigenous and dalit (the lowest level in the now unlawful caste hierarchy) women in facilities prompted an independent investigation by NGOs. The report, which detailed individual case studies, found that a disturbing lack of accountability, discrimination and negligence was directed at these women which led to the high rate of maternal death.¹²² According to UNICEF, 61% of the maternal deaths in India are suffered by dalit and indigenous communities. The Indian Government continues to pursue its policies.

¹²⁰ Our contact requested us to remain anonymous due to fear of retaliation.

¹²¹ Our source of information requests absolute confidentiality as she has previously received life threats for venting similar issues.

¹²² Subha Sri B, Sarojini N & Renu Khanna (2012) An investigation of maternal deaths following public protests in a tribal district of Madhya Pradesh, central India, *Reproductive Health Matters*, 20:39, 11-20, DOI: 10.1016/S0968-8080(12)39599-2

Argentina

According to a report released by the Argentinian Observatory of Obstetric Violence¹²³ (OVO Argentina), based on statistical data from 4939 reported births, 2.5 out of 10 women were criticized for expressing their emotions during labor and delivery, 2.7 out of 10 women received ironic or disqualifying comments. Around 5.3 out of 10 women were called with nicknames or diminutives like “chubby girl, mammy, or baby”. Many of them referred to their childbirth as “the worst day of their lives” or that they “just wanted it to be over” not because of the intensity of labor itself but because of the hostile and violent environment in which they gave birth.

Spain

Similarly, according to the data collected by the Spanish Observatory of Obstetric Violence¹²⁴ from 1815 births in Spain, 40% of women declared that health care providers did not use a professional or correct language, 33,8% were told that “they were doing it wrong” and in 32,5% of cases women were criticized for their expressions of pain, shouts or moans. Similar results are reported in Croatia, Italy and Slovakia.

Hungary

“Next time I choose the same doctor...I always reminded him what happened last time, and he said yes this time everything will be okay. I told him my plan, that I really want to deliver this baby naturally. He said that there is no problem, I can do that. This is how I spent another 9 month with a totally healthy, uneventful pregnancy. We were both doing perfect but they wanted to admit me at the 39th week as the “protocol” says but I said no. After this no, I was not able to reach out to my doctor. I was not able to talk to him, anything. His assistant gave me the appointment for c section for exactly on my due date. I wanted to talk to my doctor to discuss if we could wait a bit more, if he could check me but I was not able to reach him. We only met on that morning when I had the appointment for c section. I told the anesthesiologist to postpone the surgery because I was coughing. She said she can do the surgery but she is also not ok with my condition. She went after my doctor, but he said we will have the surgery. I wanted the best for my baby, so I had a c section. The baby was born healthy with apgar 10-10 but they did not give her to my husband. They woke me up so I could see her in clothes but

¹²³ OVO Las Casildas is a non-governmental organization with the mission of visibilizing the issues of Obstetric Violence in Argentina. The work of Las Casildas has been officially declared of social interest in health care matters by the local legislators of Buenos Aires.

¹²⁴ Released by the non-governmental association El Parto es Nuestro in 2016.

*then they take her away. Few minutes later a nurse came, she said this is not allowed, but she gave us the baby and we were able to spend 30 minutes together. I was coughing badly and I had to ask for a medicine several times and I hardly got some. I told my doctor again that I am not feeling well. I am coughing a lot, and it is terrible with a c section. I asked him to do an ultrasound before I leave because what happened last time, but he said no, he sees now everything is fine. I went home. Next evening I was watching the tv when I felt something warm coming down my feet. I held the baby so I thought her diaper soaked through, but when I looked down there was blood everywhere. Then I thought it's my pad, but I realized my wound is fully open. I grabbed a white t-shirt to stop the bleeding and my husband drove 1 hour to the hospital with me and the newborn. At the hospital the doctor was able to lift my whole belly up and they said I have to stay on the bed because my bowels are out. They called my private doctor in, who performed another surgery on me. The next day he apologized. I remember before they put me to sleep there was a resident when my baby was born. Maybe not my doctor sewed me together. I do not really know what went wrong. I asked for my documentation but there is nothing in it. The paper work just states that my incision opened in its whole deep, they cleaned my abdomen and sewed me back. I did not give him money this time but I attended his private care and I paid for 9 months. I thought this time this was more than enough. The whole system is corrupt. Some doctors would directly ask for *hálapénz* ("under the counter payments") - Details withheld.*

(b) Violation of the prohibition against cruel and inhuman treatment

Article 7 of the International Covenant on Civil and Political Rights (ICCPR) prohibits cruel, inhuman or degrading treatment or punishment. Similar provisions are contained in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) and the Convention on the Rights of Persons with Disabilities (CRPD).

The treatment that some of the most vulnerable women in the world receive in pregnancy and childbirth can and must be characterised as cruel and inhuman treatment.

Bulgaria

In 2016, the Bulgarian Helsinki Committee asked the European Court of Human Rights to issue interim measures to protect the home delivery of a pregnant woman, specifically to protect her careproviders from penal measures for assisting her third, upcoming delivery at

home.¹²⁵ The woman cited two previous horrific hospital experiences resulting in serious violations of her human rights to support her case. This included her first birth in 2008, which proceeded under medical practices that she had explicitly refused and where doctors applied the Kristeller maneuver despite protests, which resulted in the baby being born with a broken clavicle, a hematoma, and edema in the head. The application by the Committee appears to have had no impact on the health facilities in Bulgaria. In August 2018, 33-year-old Reneta Tomova died one day after the birth of her first child. She had a normal pregnancy, but following the birth and reports of loud shrieks of pain, her relatives say she suffered from broken ribs and bruising on her torso. Her condition began to deteriorate shortly after the birth. Doctors assured bystanders that the "Kristeller method", the act of putting undue downward force on a woman's fundus during labour, was perfectly acceptable and conducted under strict supervision. There is little to no evidence to support their claim.¹²⁶ Ms Tomova's newborn baby suffered paralysis of the right arm and swelling of the head.

Spain

*"I asked the doctor if [father's name] could come in to give me strength... he said 'no', [he said] that I had not behaved well, and that because I had not behaved well, the father of [name of son] could not enter"*¹²⁷

*"That lady [Another woman in labor] was giving [the hospital staff] a lot of trouble ... So a nurse said to her: 'You have to bathe with cold water and for the well behaved lady I'm going to bring you hot water'. I remember, that lady with cold [water] and me with hot"*¹²⁸

¹²⁵ BHC, "Gross Rights Violations Against Pregnant Women in Bulgaria" (July 20, 2016), <<https://www.liberties.eu/en/news/bhc-wants-interim-measures-to-protect-home-delivery/9128>>

¹²⁶ Hofmeyr GJ, Vogel JP, Cuthbert A, Singata M. Fundal pressure during the second stage of labour. Cochrane Database of Systematic Reviews 2017, Issue 3. Art. No.: CD006067. DOI: 10.1002/14651858.CD006067.pub3.

¹²⁷ Sanchez, Rodriguez Martinez, Torres Castro "ME DES-CUIDARON EL PARTO": LA VIOLENCIA OBSTÉTRICA Y EL CUIDADO RECIBIDO POR EL PERSONAL DE LA SALUD A MUJERES DURANTE SU PROCESO DE PARTO.

(Available online at <https://repository.javeriana.edu.co/bitstream/handle/10554/20447/RodriguezMartinezDaniela2016.pdf?sequence=1&isAllowed=y>)

¹²⁸ Ibid

"[At the time of the massage to expel the lochia] That was horrible because [the midwife] opened my postpartum diaper and one showing everything to the world, and she started to prod, it hurt a lot. And me, I am usually very obedient, very judicious, but I held her hands and said: No, no, no, It hurts! And the doctor, the same big man arrives and says: 'But that does not hurt ... So the obstetrics book a hundred years ago is wrong ?!'"¹²⁹

Ireland

Hundreds of women had to fight for many, many years for accountability and compensation for symphysiotomies (the practice of sawing through or breaking the pelvic bones) performed without their consent¹³⁰, despite enduring decades of chronic pain, incontinence, walking difficulties, sexual problems and other issues for their entire lives. At the time this procedure was in use, there was significant evidence indicating that the practice was dangerous and outdated. In honour of the immense suffering endured by these women and their families for decades, we have set out some of their stories.

Mary: *"When the doctor arrived, he did something I will never forget. They gave me gas and air and an injection, and took me to another room, where they tied my legs up on each side," she recalls. "There were two nurses on each side of me. I saw this doctor at the end of my bed with a big, long silver thing. They made a hole in your private parts, and he inserted this silver thing up and cut the pubic bone and pushed it over to widen your pelvis for you to deliver your baby yourself."*

Cora: *"I was screaming. It's not working, [the anaesthetic] I said, I can feel everything ... I saw him go and take out a proper hacksaw, like a wood saw...a half-circle with a straight blade and a handle...The blood shot up to the ceiling, up onto his glasses, all over the nurses....Then he goes to the table, and gets something like a solder iron and puts it on me, and stopped the bleeding. ...They told me to push her out, she must have been out before they burnt me. He put the two bones together, there was a burning pain, I knew I was going to die.*

Despite the hard work and efforts of the Survivors, HRiC has just received reports of the revival of a non-surgical version of the practice, allegedly called "spontaneous symphysiotomy" which is having the same devastating results for mothers. Women are

¹²⁹ Ibid

¹³⁰ Khaleeli, H. "Symphysiotomy – Ireland's brutal alternative to caesareans" (2014) The Guardian <<https://www.theguardian.com/lifeandstyle/2014/dec/12/symphysiotomy-irelands-brutal-alternative-to-caesareans>>, see also Survivors of Symphysiotomy: Submission to the United Nations Committee on Torture.

being aggressively induced, forced to lie back during the induction and made to put pressure on their feet while pushing:

“Lying flat on one’s back not only hurts a great deal more, but it means that all of the expansion of the birth canal which happens during labour is at the front, and that position is therefore much more likely to result in injury to the symphysis pubis. Mine tore. I can remember feeling one half rubbing off the other when I tried to walk in the days immediately afterwards. I was only able to walk using a walker, by swinging one leg, and then the other. Weight from the upper body is normally transferred through the pelvis, which also coordinates movement between both legs. I couldn’t take any weight on my pelvis...I told the consultant on his rounds on day two or three that I couldn’t walk (I was being quite literal) and was immediately asked if I could walk to the bathroom halfway up the corridor. On a walker it took me about five minutes, and ten minutes to walk the corridor to the shower at the end of the ward, a distance of maybe 30 yards. I had to put all of my weight onto walks and swing each leg out and then put my foot on the floor, and then repeat with the other leg... Dr B rather bizarrely asked if there had been any sign of this (pelvic problem) during the pregnancy, even though he was the only doctor who had attended me throughout, and had checked on my symphysis few weeks previously (it had risen very slightly). He then remarked that they were seeing a lot of ‘spontaneous’ symphysiotomies over the last couple of years. My general impression at the time was that what he had done was quite deliberate. This opinion is shared by the two other women whom he injured, and to whom I have spoken, one of whom is a nurse. Another acquaintance, a former nurse, told me that the local GPs simply stopped referring to him. The HSE simply appointed another obstetrician and moved him ‘sideways’. For the first few days I could actually feel both halves of the symphysis rubbing off one another when I moved. I was discharged after five days still unable to walk, with no mention of follow-up or physio. I was told in the hospital at the time that there was nothing that could be done. This is not correct.” - C.D

Croatia

<https://www.facebook.com/PrekinimoSutnjuRoda/videos/2138927943023172/?t=7>

This link will take you to the testimony of Croatian Member of Parliament Ivana Ninčević Lesandrić who, on October 11th, 2018, stood up and told her very personal story of obstetric violence to the House and Minister of Health.

“I had a miscarriage. They tied my hands and feet and began the curettage procedure without any anaesthesia. They scraped my uterus without anaesthesia. Those were the most torturous 30 minutes in my life. I can describe every second to you because they

were the worst 30 minutes of my life. Thirty minutes of degradation for every one of the thousands of women who have signed petitions to end this type of care.” The Speaker of the House reprimanded her for going over her allotted time and told her that she had put him in a very uncomfortable position telling such an intimate story in the Parliament. The Minister of Health, who was also present, responded to her statement by saying: *“Croatian hospitals don't do things like that. Give me your medical documentation so I can explain why anesthesia was contraindicated.”*

"As a medical student in gynecology, doing my practice at Petrova Hospital in 2002, I personally witnessed follicle aspiration in medically assisted insemination many times. Absolutely all procedures, without exception, were performed without any anesthesia. The faces and pain of those women were clearly engraved in my memory as something I never wanted to go through. No less impressive were the comments of the staff who performed the procedure (gynecologists, nurses)- “Calm down already“ and “Stop whining“. As a doctor, I am simply ashamed, that today, years later, the same *procedures are being routinely done without anesthesia!!!*"

Argentina

Incarcerated pregnant women forced to remain handcuffed or strapped to a bed while in labor and delivery, a usual practice that amounts to torture and degrading treatment, is often combined with verbal and other forms of mistreatment that are associated with their status of “deprived of their liberty”. *“The nurse did not want to give me water because I was an inmate”, “... I did not feel the same as the others. They [by the doctors] marked a difference ...”, “The nurse and the doctors felt uncomfortable to see public force staff and were obfuscated”, “When I arrived at the hospital, they [hospital staff] asked me about the cause of my detention...”, “They asked me for how long I have been detained”, “They told me it was a nuisance to have me there”.*¹³¹

¹³¹ HRiC translation from the publication “Giving birth like an inmate “Experiences of obstetric violence of women deprived of liberty”. Procuración Penitenciaria de La Nación Argentina “Parí como una condenada : experiencias de violencia obstétrica de mujeres privadas de la libertad” - 1a ed . - Ciudad Autónoma de Buenos Aires : Procuración Penitenciaria de la Nación ; La Plata : Defensoría del Pueblo de la provincia de Buenos Aires ; CABA : Defensoría del Pueblo de la Nación ; CABA : Ministerio Público de la Defensa de la Nación, 2019. Libro digital, PDF Archivo Digital: descarga y online ISBN 978-987-3936-14-2, 1. Mujeres. 2. Modalidades de Violencia de Género. 3. Encarcelamiento. I. Título.

“They smashed my vagina with an unnecessary ventouse -which was wrongly applied- only because they wanted to finish their shift earlier. 3 reconstructive vaginoplasty... 2 years without sex”¹³²

2) Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care;

Full and informed consent is only complete if the health care provider explains the health status of the woman and her fetus, and provides complete and unbiased evidence-based information regarding her health care options and its risks, it also entails including the option to not perform any treatment. The woman should be given time, without pressure, to consider her options and decide.

Despite the ethical and legal obligations of facility based health care providers to obtain full and informed consent to medical procedures, it is rare in medical practice in maternal health. Informed consent not administered, and worse, women who attempt to refuse medical treatment are often disregarded and some forced against their will to undergo procedures, including surgical interventions of their bodies.

¹³² A woman’s experience in an Italian hospital, extracted from the media campaign #bastatacere Le Donne hanno voce (Break the silence, women have a voice). More than 1000 women told their stories of Obstetric Violence in the context of the campaign launched in 2016 by OVOItalia. See report online at <https://ovoitalia.wordpress.com/2016/06/20/bastatacere-report/>

3) Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations;

In middle to high income countries, mechanisms for establishing accountability have been established to facilitate internal accountability through a process of investigations, review and reporting. States implement and oversee professional guidelines and protocols for reviews but consumers are precluded from providing input in relation to the investigation or reporting stages. These same guidelines and protocols, together with professional obligations form part of the bundle of practice standards used to assess complaints and civil claims brought by consumers to facilities and health systems.

In low to middle income countries, practice standards, accountability mechanisms and consistent management of investigations and reporting is rare, although medical malpractice does play a role through British born common law systems.

We have set out below some of the accountability mechanisms with which HRiC has had direct involvement. In all the options explored, it is clear that there is a chasm between medicine, the law and the human rights of pregnant and birthing people. The mechanism for individual and consumer redress are developing out of sync with the maternal human rights.

Making a Complaint

Studies indicate that women prefer to use complaint mechanisms for altruistic reasons, with litigation viewed as a final or self indulgent resort. They will turn first to their careprovider and, if not satisfied, turn to formal complaints. Many pursue complaints in the belief that they can help protect others from suffering these harms in the future.¹³³

¹³³ Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. Health & Life Sci. L. 125, 133 (2009).

“I’ve tried to write my story to my state’s medical board. Every time I try though, I hear [the doctor’s] voice jeering at me telling me I’m just a baby crying for not getting her way. If writing my story helps just one woman avoid the abuse I’ve experienced, it was worth the pain of remembering.” – Anonymous 3

“I hope change is made in how doctors treat women during childbirth. It is an absolute disgrace what is happening now.” – M. H.

For some time now, consumer complaints mechanisms were lauded as an effective teaching opportunity to enhance patient satisfaction and improve practice within facilities. For the states that support consumer complaints, however, significant barriers are raised against effective accountability or resolution for birthing women. Prompt action and appropriate responses are rare. For example, a physician was caught on camera in 2014 performing a repeated episiotomy contrary to the patient’s express request¹³⁴ did not respond to the complainant until the video went viral, and media attention was raised. The physician was ultimately forced to hand over his medical license as part of a settlement. Such cases are rare.

Women report that:

- (a) the practice standards are, in themselves, influencing the type of care they receive and the violations that result;
- (b) practice standards prioritise outcomes, not trauma or informed consent;
- (c) their complaints are referred back to professional bodies with a vested interest in maintaining the current structures¹³⁵;
- (d) complaints are given the same treatment that the women received in hospital - women’s concerns are ignored or dismissed.¹³⁶

¹³⁴ Kimberly Turbin’s Forced Episiotomy Case: The Resolution, IMPROVING BIRTH (Mar. 16, 2017), <http://improvingbirth.org/kimberlys-case-the-resolution> [<https://perma.cc/92LGGQYT>]. The original video can still be found online. Rios jahir, Birth Video Epidural and Episiotomy, YOUTUBE (Aug. 27, 2014), <https://youtu.be/lCfXxt0AN-I>.

¹³⁵ Reiger, M “Knights” or “knaves”? Public policy, professional power, and reforming maternity services” [Health Care Women Int.](https://doi.org/10.1080/07399332.2010.529218) 2011 Jan;32(1):2-22. doi: 10.1080/07399332.2010.529218.

¹³⁶ Davey, M “A decade after the Butcher of Bega, red flags are still being missed” (2018) The Guardian Au (27 June) <https://www.theguardian.com/australia-news/2018/jun/28/a-decade-after-the-butcher-of-bega-red-flags-continue-to-be-missed?CMP=share_btn_link>.

...[I] was belittled, laughed at, ignored and told I had "issues" by L&D nurses, the hospitals' risk manager, the hospitals' CEO, and AHCA , the board that is supposed to regulate hospitals. These people DID NOTHING.
– V. M.

Recent studies indicate that careproviders do not recognise the altruistic components of women's complaints. Instead, complaints were viewed as coming from patients who were inexperienced, distressed or advantage-seeking. Personnel rarely saw complaints as an opportunity for improvement in quality of care. Staff merely assumed that their role was to be the decision maker and empathetic listener.¹³⁷

Several months afterward, I asked to meet with the doctor and nurse(s) who attended my birth, but the hospital denied my request. The hospital did allow me to meet with the head of OB/GYN and head of L&D nursing. ... Both of the hospital officials expressed sympathy for my trauma and said they were sorry I was unhappy with my care. However, they firmly stated that all women deliver on their backs in that hospital, and if a woman is not on her back when the doctor wants her to be, she will be forcibly moved into that position. They said they were sorry there had not been time for the doctor to explain that this was the way their hospital worked. They promised to implement new training to help nurses be more gentle when they forced women on to their backs. I did follow up to see what sort of new training they had implemented, but they did not give me any information. – J. R.

Within the prevalent and systemic facility workplace culture, anyone viewed as the 'other', including potential newcomer or junior staff within the system who complain, are ignored or dismissed.

"I've recently seen an example of what I would call obstetric violence, and it showed me that sometimes it doesn't matter how educated or empowered

¹³⁷ Mary Adams, Jill Maben and Glenn Robert, "It's sometimes hard to tell what patients are playing at': How healthcare professionals make sense of why patients and families complain about care" (2018) *Health* 2018, Vol. 22(6) 603–623

the woman is, sometimes obstetricians just feel as though their medical training gives them authority over a woman's body during labour and birth. We can make reports and we can escalate them, but this perceived authority seems to be a culture amongst a significant proportion of obstetricians. I don't know what questions to ask to make it better, I don't know if new or reformed laws would help, or if there needs to be more rounded education at university level - and if it's the fear of normal, because they are surrounded by abnormal every day, which drives some Obs, how do we change that?" - Student Midwife, Vic

"As a midwife working in hospital, how do I navigate around a consultant obstetrician/registrar telling a woman her baby will 'die' or 'do you want to keep your baby safe' if she doesn't partake in a certain action? This is coercion and a play on the woman's most vulnerable moment of her life and language that I have never felt comfortable with. How do we move forward to change this?" - Graduate Midwife, Vic

The Civil Justice System

Access to justice has always proved challenging for women, let alone those who have suffered violations of informed consent and refusal during childbirth. This is all the more so if they are economically or racially disadvantaged.

Access requires either the availability of a publicly funded lawyer, funds to retain a privately funded lawyer, or reliance on a contingency fee structure, if it is available. Public attorneys' in most states priorities criminal defence over civil prosecutions. Privately funded lawyers are price prohibitive for most new parents and would be considered an indulgence for most.

The contingency fee structure, even if available in a states, is assumed to address solutions to access problems and a means of redress for the most vulnerable and most injured. Unfortunately, it also presents access challenges for women. The contingency fee structure's efficacy is predicated on a case's promise of sufficient returns to address both compensation and damages to cover the costs of bringing the case. Contingency fee lawyers will take the cases they expect to award significant damages for violations of informed consent in maternity care. Women of color and other marginalized communities, in particular, suffer

from inequitable access to redress and accountability for violations like forced surgery. Many women, Ms Dray included, struggle to find a contingency fee lawyer to take their case.¹³⁸

Although privilege and socio- economic status may not protect women from experiencing force and abuse in childbirth, it does help them later to find lawyers willing to advocate on their behalf.

Medical Malpractice Law

For women, access to redress is hampered by a number of factors:

(a) Gender bias in the legal system

Precedent findings in medical malpractice cases that downgrade maternal injury. Consequently, limits on potential damages, as well as the statutory barriers make these cases less attractive to lawyers.¹³⁹ This constitutes a barrier to access that prevents a legal remedy even before courts have a chance to examine the claim; Gender bias that discourages health care professionals from accepting the views of expectant mothers also fuels the pattern, while the challenge of proving that harms resulted from forced surgeries undermines patients' efforts to seek redress.

Winning is rare in maternal injury claims and often is justified only because of serious or permanent maternal injury. In the aforementioned Rinat Dray case¹⁴⁰, for instance, a mid-level New York Appeals court ruled against Ms. Dray, asserting, somewhat astonishingly, that “*the state interest in the well-being of a viable foetus is sufficient to override a mother’s objection to medical treatment*”.

(b) Gender bias in the broader socio-economic system

Medical malpractice lawyers tend to believe in, and weigh on the side of, physician value-sets such as “doctor knows best” and patients are naive or ignorant. In most cases, these values are used to their advantage. When, however, it is used to pitch one patient against (a fictional other), these values lend themselves to a culture of overriding consent.

¹³⁸ Dray v Statten Island Hospital et al, note 85, at 93.

¹³⁹ Farah Diaz-Tello, Invisible Wounds: Obstetric Violence in the United States, 47 REPROD. HEALTH MATTERS 56, 57 (2016)

¹⁴⁰ Dray v Statten Island Hospital et al, note 85.

Many women are told that injury and suffering during childbirth is inevitable, and that a mother should be grateful to have a healthy baby. This is constantly reinforced by both careproviders and loved ones.¹⁴¹

“I talked to my husband about it, and while he was so supportive and kind, he ultimately told me I got my healthy baby and that we were all ok, and that was what I needed to focus on. Everyone told me that. – M.H.”

(c) Foetal-centric focus in assessment of damages

Courts, and lawyers, tend to privilege claims for damages to fetuses or babies over those of mothers:

In the few cases where birthing women have prevailed in maternal harms cases, it is generally through a fetal injury derivative claim where-even in these cases-courts still have to press heavily to maintain the viability of a stand-alone maternal harms claim and defense counsel remains incredulous.¹⁴²

(d) Mothers downplay their own physical injuries, while the courts and the law downplay psychological harm¹⁴³:

I have not sought any legal action because I don't have serious medical complications from the birth, unless you count a scarred, torn urethra..... – Anonymous 1

In many cases, however, that psychological harm may hamper a distressed new mother's ability to pursue redress:

I did not take any legal action. I was busy healing and nursing round the clock and I was so so so angry and sad about the whole thing that I could barely even talk about it without crying. ... I still don't think anyone at the hospital would care how I was treated. I was a home birth transfer, some

¹⁴¹ Cheryl Beck, *Birth trauma: in the eye of the beholder*, 53 Nursing Res. 28-35 (2004).

¹⁴² Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 Cardozo L. Rev. 1955, 1980 (2012-13).

¹⁴³ Daniel Givelber, *The Right to Minimum Social Decency and the Limits of Evenhandedness: Intentional Infliction of Emotional Distress by Outrageous Conduct*, 82 Colum. L. Rev. 42, 44- 60 (1982).

ignorant hippy or whatever, so clearly the Dr was just doing what needed to be done and I was hindering his care for myself and my baby, who I had placed in grave danger by not coming straight to the hospital when I began labor. –P. B.

In recent years, and through global economic downturns, tort reform has proven to be the favourite political undertaking of states to reign in perceived excesses of the civil justice system. Of the austerity measures imposed under that umbrella, caps on non-economic damages or strict time limitations on claims are the favored approach. Strictures vary among states, but some are so extreme that recovery is considerably hampered:

“Health professionals have often actively lobbied for caps on non-economic damages, whereas consumer advocates have generally held that such limits ... are unfair to injured parties and *especially* create burdens for those with more serious injury. Further, caps may provide a disincentive for lawyers to take clients with meritorious cases and reduce incentives for deterring harm.”¹⁴⁴

“I called over one hundred attorneys and only one took my case. He said the same thing the others did. That Florida is an impossible state to recover damages from medical malpractice, that he would have to try it as a battery... He went ahead, and my case was dismissed on "summary judgment" that my medical malpractice claim was couched as a battery!” – V. M.

The Problem with Medical Malpractice Law

Medical malpractice liability and defensive medicine feature heavily in the practice of careproviders in medical malpractice jurisdictions. Successful compensation claims turn into insurer’s conditions for practice which turn into hospital policies. Doctors commonly report that liability hangs, like the sword of Damocles, above their heads, and that that liability mandates the overuse of interventions in maternity care and the overriding of informed consent. The reality is somewhat more complex - these perceptions aren't the only factors to

¹⁴⁴ Carol Sakala et al., *Maternity Care and Liability: Least Promising Policy Strategies for Improvement*, 23 *Women's Health Issues* e15, e17-18 (Jan. 2013) [hereinafter *Sakala, Least Promising*]

drive their practice.¹⁴⁵ Even with tort reforms providing greater protection from liability, doctors have not necessarily reduced their intervention rates.¹⁴⁶ As we have noted throughout this report, far more serious and profound matters are at play.¹⁴⁷ These include, but are not limited to:

- (a) meeting changing regulatory requirements;
- (b) endorsing the more restrictive practices of colleagues to boost the volume of deliveries and/or recover higher reimbursement rates; and
- (c) schedule procedures for the sake of convenience.

The result is a legal system that, in substance, protects care providers' widespread preference for surgical interventions and active management of birth, together with the abrogation of informed consent.

The Criminal Justice System

In Latin America, since the 1990s, the Humanise Birth Movement has fought for and encouraged recognition of disrespectful maternity care as a widespread issue, culminating in the implementation of laws that acknowledge Obstetric Violence as a form of gender-based violence against women. As early as 2006, Venezuela incorporated the concept to its legal framework, defining Obstetric Violence as:

*“the appropriation of the body and women's reproductive processes by health care personnel, that is expressed in a dehumanizing treatment, in a abuse of medicalization and pathologization of natural processes, bringing with it loss of autonomy and ability to freely decide on their bodies and sexuality, negatively impacting in the quality of life of women”*¹⁴⁸

¹⁴⁵ Cano Urbina, Javier. “Do Tort Reforms Impact the Incidence of Birth by Cesarean Section? A Reassessment.” *International journal of health economics and management*.17.1 1–10. Web.

¹⁴⁶ Chen, Brian K. “Increased Perception of Malpractice Liability and the Practice of Defensive Medicine.” *Journal of empirical legal studies*.11.3 446–476. Web.

¹⁴⁷ Janet Currie & W. Bentley MacLeod, *First Do No Harm? Tort Reforms and Birth Outcomes*,123 Q. J. Econ. 795 (2008);

¹⁴⁸ English translation of Section 15(13) “Ley Orgánica Sobre el Derecho de las Mujeres a una vida libre de Violencia”.

Argentina, Panama, some Mexican states, Bolivia and El Salvador have since followed suit. Despite the existence of these prohibitions, enforcement is light and rarely pursued.

Medical professional bodies have reacted negatively to the prohibitions introduced in their respective states. In 2018, the Federal Council of Medicine of Brazil (FCM) described the term "obstetric violence" as a form of aggressiveness towards doctors and went on to state that, "*in their vast majority [doctors are] committed to good care and respect for their patients, and who, due to a misperception of some segments, have had their participation diminished and questioned in the care process*"¹⁴⁹. The FCM was supported by the Brazilian Ministry of Health in May 2019, when the Ministry advocated to abolish the term "Obstetric Violence" altogether.^{150 151}

Human Rights Justice System

In middle to high income countries, civil rights and human rights violations are ordinarily overseen by an administrative authority with the power to investigate and issue recommendations, particularly in relation to violations by public facilities, and if necessary commence prosecutions on behalf of individuals wronged. As there are no maternal human rights, other than the specific right to workplace protections during pregnancy, the institutions do not recognise or receive complaints brought for violations in childbirth.

For a brief time in Europe, there was a short lived attempt, by NGOs, to develop human rights precedents aimed at increasing recognition for women's human right to autonomy and bodily integrity in pregnancy and childbirth. In 2010, the European Court of Human Rights declared that the the circumstances of giving birth incontestably formed part of a person's private life for the purposes of Article 8 of the European Convention on Human Rights.¹⁵² The Court found that the applicant, Ms Ternovszky, was in effect not free to choose to give birth at home because of the permanent threat of (criminal) prosecution faced by health

¹⁴⁹ Available online at <http://portal.cfm.org.br/images/PDF/nota-violencia-obstetrica.pdf>

¹⁵⁰ Position Statement of 3 May 2019 by the Ministry of Health Secretariat of Health Care Department of Strategic Programmatic Actions (Available online at https://sei.saude.gov.br/sei/controlador_externo.php?acao=documento_conferir&codigo_verificador=9087621&codigo_crc=1A6F34C4&hash_download=3a1a0ad9a9529cf66ec09da0eaa100f43e3a71dadcb400a0033aeade6e480607ee223e8f2fb1395ed3ce25c6062032968378cd9f7a37a4dc6dfb5a3aa708709d&visualizacao=1&id_orgao_acao_externo=0)

¹⁵¹ See source at footnote 9 in this document.

¹⁵² Ternovszky v. Hungary (2010) ECHR (Strasbourg) (Application no. 67545/09) <<http://hudoc.echr.coe.int/app/conversion/pdf/?Library=ECHR&id=001-102254&filename=001-102254.pdf>> at p22.

professionals who sought to assist her, in this case, a midwife who specialised in providing homebirth intrapartum care. The Court noted the absence of specific and comprehensive legislation on the issue of home birth in Hungary.

The Ternovsky decision was considered a landmark decision because of its affirmation that the freedom to choose the circumstances of childbirth was a woman's right to privacy and family life under Article 8, rather than a medical careprovider or the state's decision to do so. It also paved the way for a human and legal rights discourse around the state's obligations in relation to regulating childbirth. This was especially relevant to the state of Hungary, where women have long reported systemic and direct abuse and disrespect in facilities during childbirth.

That said, the Ternovsky decision also imposed limits alongside the affirmation of this right which have, in effect, rendered the right meaningless. The Court noted that, in keeping with Article 8's scope as a negative right, national authorities have considerable room for manoeuvre in cases involving complex matters of health-care policy and allocation of resources. This "wide margin of appreciation" was used to deny a violation of Article 8, even where it was confirmed that the Czech Republic made it impossible in practice for women to be assisted during their home births (*Dubská and Krejzová v. the Czech Republic*¹⁵³). The Court said:

"A certain margin of appreciation is, in principle, afforded to domestic authorities as regards that assessment; its breadth depends on a number of factors dictated by the particular case. The margin will tend to be relatively narrow where the right at stake is crucial to the individual's effective enjoyment of intimate or key rights. Where a particularly important facet of an individual's existence or identity is at stake, the margin allowed to the State will also be restricted. Where there is no consensus within the member States of the Council of Europe, either as to the relative importance of the interest at stake or as to the best means of protecting it, particularly where the case raises sensitive moral or ethical issues, the margin will be wider.

¹⁵³ *Dubská and Krejzová v. the Czech Republic* (2014) ECHR Strasbourg (Applications nos. [28859/11](#) and [28473/12](#)), <

A wide margin is usually allowed to the State under the Convention when it comes to general measures of economic or social strategy. Because of their direct knowledge of their society and its needs, the national authorities are in principle better placed than the international judge to appreciate what is in the public interest on social or economic grounds, and the Court will generally respect the legislature's policy choice unless it is "manifestly without reasonable foundation".

But just how wide is that margin of appreciation going to be? In *Pojatina v Croatia*¹⁵⁴, a case filed in 2012, Ms Pojatina argued that the complex and potentially criminal implications for midwives seeking to assist her in a homebirth rendered her right to choose the circumstances of her birth nugatory or meaningless. She submitted evidence of horrific treatment in hospitals, problems with the Croatian legal system and the police investigations that were conducted after she presented with her newborn to a medical practitioner. The Court gave the State of Croatia a wide margin of appreciation because of the fact that there is currently no consensus amongst member States of the Council of Europe in favour of allowing home births and because it was satisfied that the State was taking measures to address the uncertainties leading to the potential for an Article 8 violation.

In 2019, Ms Pojatina filed an appeal on the basis that the State had, after 7 years, failed to make the adjustments it offered the Court in the initial application. Her appeal was rejected without reasons.

In substance, while asserting a woman's right to determine the circumstances of birth, the European Court of Human Rights has essentially rendered that right meaningless by:

(a) offering States a wide margin of appreciation, which could extend beyond 7 years, to attempt to implement a system of care which women have now been requesting for several decades;

(b) describing women's attempts to birth outside of hospital not as a key human right but as a socially desirable or "preferred" action; and

¹⁵⁴ *POJATINA v. CROATIA* (2019) ECHR(Application no.

(c) giving voice to, and in effect, supporting the lack of consensus amongst European States to womens' rights to choose the circumstances of their birth.

4) Does your health systems have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue?

New Zealand

“The New Zealand Government has health policies that are supposed to guide health responses to Maori health needs, but these are completely ignored. The paternalistic role the state continues to load over Indigenous women, and their babies in insidious, and ongoing. There are 21 District Health Boards in New Zealand (DHB). Each has the responsibility to provide maternity care to its population. One of the serious flaws with the DHBs is that over 90% of all managerial staff, and heads of department are immigrants. There is only one Maori Midwife manager at ADHB and DHB. Because Maori are under represented in management roles, and decision-making roles, the population of Maori suffer. All indicators are that the HEALTH CARE WORKFORCE population must resemble the population they serve, for there to be any real understanding of their health needs. This does not happen in New Zealand. Even the midwifery workforce, who birth 98% of all babies born in New Zealand, 3450 midwives, 2000 of them are immigrant overseas midwives, with the balance of 1500 being New Zealand midwives, of which only 200 are Maori midwives.” - Jean Te Huia

Croatia

Since 2016, the Croatian Ombudswoman for Gender Equality has had a section on the Right to Respectful Care in Maternity Hospitals in her annual report¹⁵⁵ and the People's Ombudswoman have all warned about these issues, but there has not been any meaningful improvement.

Mexico

Mexican health systems have over 32 policies that refer to respectful and quality in maternal health. However, a wider culture of impunity in the legal system, lack of resources in public

¹⁵⁵ Ombudswoman for Gender Equality, report for 2016, page 280, http://www.prs.hr/attachments/article/2188/IZVJESCE_2016_Pravobraniteljica_za_ravnopravnost_spolova_CJELOVITO.pdf

health, structural inequalities and levels of accepted VAW and femicide in the broader society contribute to the difficulty of holding to legislation and protection of human rights.

In most Latin American countries, an Independent Ombudsman is given the responsibility are mandated to address such human rights violations. The Iberoamerican Federation of Ombudsman (FIO) held some meetings with the purpose of monitoring the situation in the region. However, a final document has not been completed.¹⁵⁶ The Argentinian Ombudsman released a document whereby he expressed concern about the issue in his country.¹⁵⁷ Also in Argentina, the official institutions in charge of addressing issues of gender-based violence and discrimination, are also respectively mandated to receive complaints from women, investigate and issue recommendations to the hospital, should they find that Obstetric Violence has taken place. Women may also seek justice through a summary process before a court of law of their choice, with legal representation free of charge.

Recommendations

To ensure the inclusion of women's voices, authorities at all levels must support and partner with grassroots organisations in the decision making process.

Human Rights in Childbirth respectfully requests that the Special Rapporteur consider the implementation and monitoring of the following actions:

1. Convene a forum for maternal health rights advocates and lawyers to develop and frame a specific set of maternal human rights for inclusion in the International Declaration on the Elimination of Violence Against Women to, at minimise, recognise:
 - a. the right to bond with and not be separated from our infants;
 - b. freedom from violence and discrimination in healthcare settings;
 - c. the right to where and with whom we choose to birth; and
 - d. the right to informed consent;
 - e. the right to attend health facilities without fear of coercion from enforcement, the judiciary or child protection services.

¹⁵⁶ FIO's portfolio on obstetric violence available online at <http://www.portalfio.org/?s=violencia+obstetrica>

¹⁵⁷ Document dated 15 April 2019, available online at http://www.dpn.gob.ar/documentos/RES_00036.19.pdf

2. Call for states to begin immediately costing and integrating options for women to decide how, where, when and with whom to give birth, including removing obstacles to birth centers and home birth options;
3. Call for states to develop institutions for the independent monitoring, advocacy and protection of maternal rights and to recognise obstetric violence as a form of gender based violence against women;
4. Recommend that state and healthcare systems incorporate scrutiny and oversight by independent human rights lawyers with sexual and reproductive health rights knowledge in relation to healthcare education programs, facility based induction and training, policies, guidelines and professional standards;
5. Incorporate age appropriate sex education, including elements of the physiology of childbirth as a healthy, undisturbed human event, in primary schools;
6. Require the disclosure by careproviders, health facilities and states of all intervention rates and practices, whether or not evidence based;
7. Mandatory inclusion in all medical, nursing and midwifery syllabi of human rights in childbirth and maternal rights.

Human Rights in Childbirth

Sydney, 17 May 2019