



## Make Mothers Matter Submission

**For the UN rapporteur on violence against women  
on Mistreatment and violence against women  
during reproductive health care  
with a focus on childbirth**

### **1) Introduction**

Make Mothers Matter welcomes the initiative of the United Nations Special Rapporteur on violence against women to finally address an important issue that is omnipresent in both developed and developing countries but has remained unseen to most people due to a lack of exposure and consideration. We hope that her report will finally bring a much-needed visibility, as a first step to encourage governments to tackle the challenge of obstetric violence and generate systemic change.

As an International NGO with member associations and partners in several European countries, Make Mothers Matter has the advantage of having access to a significant amount of information and can thus present a global depiction of the violation of the human rights of women during childbirth in Europe. With this report, the objective of MMM is to present a short and holistic picture of the issue of human rights in childbirth, an issue requiring urgent action.

The information collected for this report comes from the civil society organizations, that participated at the Fourth European Summit on Human Rights in Childbirth<sup>1</sup>, that took place in Strasbourg on October 2016. This Summit was co-organized by Human Rights in Childbirth (HRIC), Make Mothers Matters and RODA (Parents in action). In addition, we gathered data from other civil society organisations working on this field as well as national reports done by public authorities, surveys and jurisprudence from National Courts and the European Court of Human Rights.

Those NGOs gave us the authorisation to use their work and provided us with updated information on the current situation of obstetric violence in their countries. In addition, most of these organisations indicated their intent to submit separate national country reports with national data when they are available.

### **2) State of play**

Obstetric violence occurs, from what we have seen, in every country<sup>2</sup> where information is available. Yet, the number of those countries that have taken measures to tackle this violation of human rights, by publicly addressing the issue, making official reports, or even by conducting a simple survey of the problematic, is minuscule.

The European Court of Human Rights in the *Dubská and Krejzová v. Czech Republic*<sup>3</sup> case recorded “Testimonies from Numerous Mothers” describing a plethora of human rights violations. These included forced medical procedures, unnecessary separations of mothers and babies, and mandatory

<sup>1</sup> <https://makemothersmatter.org/sommet-europeen-human-rights-in-childbirth/>

<sup>2</sup> France, Spain, Portugal, Ireland, Germany, Netherlands, Croatia, Slovakia, Hungary, Poland, Ukraine, Belgium, Luxembourg, Lithuania, UK, Italy, Romania, Greece.

<sup>3</sup> The European Court of Human Rights. case *Dubská and Krejzová v. Czech Republic* (nos. 28859/11 and 28473/12). 2014.

monitoring in hospitals for 72 hours after birth. The medical staff was described as *“arrogant, intimidating, disrespectful and patronising”*.

Apart from the initiatives from a small number of countries which have commissioned the production of official state reports, all the research and initiatives concerning the violence endured by women in pregnancy and childbirth mainly come from the civil society.

Even when governments choose to act through legislative actions, the adoption of a law forbidding certain treatments, procedures or behaviours rarely improves the situation as there is no legitimate will to ensure the enforcement of those laws.

The majority of births in Europe happen in hospitals and seldom at home or in alternative settings. It is clear that enormous progress has been achieved in reducing the maternal and infant mortality rate by investing and improving medical procedures and guidelines in hospital facilities.

However, births in hospitals tend to be over-medicalised, and in some cases disrespectful and against the woman’s will, even in the case of low-risk pregnancies. According to the WHO statement on the ‘Prevention and Elimination of Disrespect and Abuse During Childbirth’<sup>4</sup>, *“many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue”*.

Health professionals working in hospitals usually fail to recognise the reality of mistreatment and abuse in childbirth and feel threatened and attacked by the concept of obstetric violence. Child well-being, internal hospital policies and general guidelines usually prevail over women’s rights and wellbeing.

Yet, in recent years, every time an opportunity was given to women to share their experiences of obstetric violence, usually via social media or surveys, thousands of testimonials were gathered in a short period of time. This positively indicates the gravity of the situation and shows the need to create a platform for women to express their childbirth experiences. The most recent examples have all taken place on social media, with campaigns like #PrekinimoSutnju (BreakTheSilence) in Croatia, #bastacere: le mardi hanno voce” (“break the silence: mothers have voice”) in Italy, #PayeTonUtérus (Pay your uterus) in France, #Genoeggezwegen in the Netherlands, the Másállapotot campaign in Hungary<sup>5</sup> or the *Roses revolution campaign*<sup>6</sup> in several countries including Spain and Germany on the 25th of November 2018 (International Day for the Elimination of Violence against Women).

The lack of action from governments to tackle this challenge is a clear violation of human rights. When a woman is pregnant and enters a hospital, she does not lose her legal capacity and rights. Her rights should be respected and consent should be obtained during the need of medical intervention.

In the countries covered by this report, women were not believed, advocates have been publicly attacked and defamed, and there were no institutional efforts to address the issue by involving mothers and women’s groups in the discussion. Their involvement is crucial in finding the solutions for this systemic, structural and interpersonal issue where the unbalance of power and persistence of stereotypes is damaging women, mothers and babies. Obstetric violence can have significant and unmeasured repercussions on their health and wellbeing, and can even put their lives at risk.

<sup>4</sup> Prevention and elimination of disrespect and abuse during childbirth, World Health Organization, 2015.

Available from: [http://www.who.int/reproductivehealth/topics/maternal\\_perinatal/statement-childbirth/en/](http://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/).

<sup>5</sup> <https://m.facebook.com/masallapotot/>

<sup>6</sup> <https://www.rosesrevolution.com>

### **3) Definition of Obstetric Violence**

First of all, it is important to address the fact that there is no clear and agreed definition of what constitutes obstetric violence. In order to have a better understanding of what we are talking about when we talk about such violence, we must look at national legislation. The most notable definitions can be found in the legislation of some South American countries<sup>7</sup>, many of which have been pioneers in the adoption of measures protecting pregnant women.

The first official reference to this term appeared in the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women<sup>8</sup>. It was the first binding treaty in the world to recognize that violence against women constitutes a punishable violation of human rights. The Convention recommended that States "adopt legal provisions that criminalise obstetric violence" by "establishing by appropriate means the elements of what constitutes a natural process before, during and after childbirth, without excesses or arbitrarily medication, which guarantees women the manifestation of their free and voluntary consent in procedures related to their sexual and reproductive health"<sup>9</sup>. As a result, several countries<sup>10</sup> in Latin America have tried to address obstetric violence and incorporate provisions into their regulatory frameworks.

For instance, in Argentina there is a law<sup>11</sup> on humanised birth, which expresses the rights every woman has in relation to childbirth:

*Every woman, in relation to pregnancy, labour, delivery and postpartum, has the following rights:*

- a) To be informed about the different medical interventions that may take place during these processes so that they can freely choose when there are different alternatives.*
- b) To be treated with respect, and in an individual and personalized way that guarantees privacy during the entire healthcare process and takes into consideration its cultural background*
- c) To be considered, in your situation regarding the birth process, as a healthy person, so that your participation as protagonist of your own birth is facilitated.*
- d) To natural birth, respectful of biological and psychological times, avoiding invasive practices and medication that are not justified by the state of health of the parturient or unborn person.*
- e) To be informed about the evolution of their birth, the state of their son or daughter and, in general, to be involved in the different actions of the professionals.*
- f) Not to be subjected to any examination or intervention whose purpose is to investigate, except for written consent under a protocol approved by the Bioethics Committee.*
- g) To be accompanied by a person of their trust and choice during labour, delivery and postpartum.*

<sup>7</sup> Venezuela, Panama, Argentina

<sup>8</sup> Convention of Belem do Para, OEA <https://www.oas.org/juridico/english/treaties/a-61.htm>

<sup>9</sup> MESECVI Annual Report 2012.

<sup>10</sup> Panama, Venezuela, Argentina, Bolivia, Costa Rica, a state in Brazil, Mexico, Colombia, Uruguay

<sup>11</sup> Article 2, National Law 25.929 on a humanised birth - Argentina

[https://www.argentina.gob.ar/sites/default/files/ley\\_25929\\_parto\\_humanizado\\_decreto\\_web\\_0.pdf](https://www.argentina.gob.ar/sites/default/files/ley_25929_parto_humanizado_decreto_web_0.pdf)

- h) To have their son or daughter by their side during their stay in the health facility, as long as the newborn does not require special care.*
- i) To be informed, from pregnancy, about the benefits of breastfeeding and to receive support for breastfeeding.*
- j) To receive advice and information on the care of herself and the child.*
- k) To be informed specifically about the adverse effects of tobacco, alcohol and drugs on the child or herself.*

In Bolivia, the law to guarantee women a life free from violence also references obstetric violence<sup>12</sup>:

- 8) Violence and Reproductive Rights: The action or omission that prevents, limits or violates the right of women to information, guidance, comprehensive care and treatment during pregnancy or loss, delivery, puerperium and breastfeeding; to decide freely and responsibly the number and spacing of daughters and sons; to exercise their right to a safe motherhood.*
- 9) Violence in Health Services: Any discriminatory, humiliating and dehumanizing action that omits, denies or restricts access to effective and immediate care and timely information by health personnel, putting at risk the life and health of women.*

In Venezuela, the law on the protection of women includes the term obstetric violence: <sup>13</sup>

*13 ) Obstetric violence: It is understood as the appropriation of the body and reproductive processes of women by health personnel, which is expressed in a dehumanising treatment, in an abuse of medicalization and pathologization of natural processes, leading to loss of autonomy and ability to freely decide on their bodies and sexuality, negatively impacting on the quality of life of women.*

These texts show recurring elements concerning the definition of obstetric violence or mistreatment and abuse during childbirth:

- a lack of information provided to mothers before and during the birth process
- the absence of consideration for the voice of the pregnant women, which can lead to abusive and dehumanizing treatments
- the negative effects that such treatments can have on the health of the women and their babies.

For the rest of our report, those elements will constitute the meaning of the term «obstetric violence».

#### **4. Violation of human rights in childbirth**

What is really at stake when we talk about violence in childbirth? The violence here is not understood as simply isolated acts in some hospitals in a few countries, but as a systemic violation of women's human rights. These are not a few cases of malpractice by professionals failing to meet adequate standards or protocols. They show how the violence against women which is omnipresent in all of society is also present in childbirth, a vulnerable moment for women. The violation of women's human rights in childbirth is systemic. This assumption is confirmed by the 1993 UN Declaration on the

<sup>12</sup> Article 7, paragraph 8 and 9, Integrated Law to guarantee women a life free from violence in Bolivia (Law 348/2013) <http://www.sipi.siteal.iipe.unesco.org/normativas/599/ley-no-348-2013-ley-integral-para-garantizar-las-mujeres-una-vida-libre-de-violencia>

<sup>13</sup> Article 15, point 13, law on integrated protection of women - Venezuela. N. 26.485/ 2009

Elimination of Violence against Women, which states: “*violence against women constitutes a violation of the rights and fundamental freedoms of women and impairs or nullifies their enjoyment of those rights and freedoms*”<sup>14</sup>.

We believe that the malpractices observed in the medical facilities denounced by victims and made visible by activists constitute a violation of the basic human rights which are detailed in the following paragraphs.

### a) The right to autonomy

Autonomy can be described as « *the acknowledgement of a person’s right to hold views, to make choices and to take actions based on personal values and beliefs* »<sup>15</sup>. The notion is also present in article 1 of the UN Declaration on the Elimination of Violence against Women when it states that « *the term “violence against women” means any act of gender-based violence that results in [...] coercion or arbitrary deprivation of liberty, whether occurring in public or in private life* »<sup>16</sup>. When we talk about autonomy in childbirth, we are talking about the possibility for pregnant women, particularly in the case of a low-risk pregnancy, to make their own informed choices concerning the medical treatments they to receive.

In our opinion, the main issue at the core of obstetric violence is the systematic deprivation of a woman’s right to autonomy once in contact with a healthcare facility. That deprivation can be subjected in many forms, from the most blatant ones like the practice of operating without a woman’s consent, to some more devious forms like the application of so-called “hospital protocols” or the use of blank agreement forms that women are asked to sign, which allow the medical staff to do what they think is necessary without requiring any further consent. These agreement forms exist in a high share of countries: Ukraine<sup>17</sup>, Croatia<sup>18</sup>, Italy<sup>19</sup>, Romania<sup>20</sup> or Slovakia<sup>21</sup>. Even more worrisome are the reports of cases where consent has been « obtained » through pressure and coercion.

The root causes of the lack of consideration for the will of the mothers are not as simple to determine as one would think. The fact is that many of these violations occur in institutions and health systems that recognise in theory the importance of consent from their patients and have legislation, and in some cases guidelines, to ensure the respect of that notion. Some countries in Europe have implemented the WHO guidelines on intrapartum care for a positive birth experience,<sup>22</sup> although it is not very common. Yet, a pregnant woman rarely has the possibility to make her choices heard during pregnancy, labour or postpartum interventions, whereas any other kind of patient’s consent is considered.

In reality, once a pregnant woman enters a hospital or any other medical facility, she is very often deprived of her legal capacity, and reduced to a non-self-governing role, where healthcare

<sup>14</sup> Declaration on the Elimination of Violence against Women (A/RES/48/104) - 20 December 1993.

<sup>15</sup> Jaunius Gumbis, Vytaute Bacianskaite and Jurgita Randakeviciute, *Do Human Rights Guarantee Autonomy ?*, University of Vilnius. <http://www.corteidh.or.cr/tablas/r26750.pdf>

<sup>16</sup> Article 1, Declaration on the Elimination of Violence against Women ( A/RES/48/104 ) - 20 December 1993.

<sup>17</sup> S., Demianova-Ponomarenko, O., Vishkina, A., Salnykova, J., Shushailo and A., Dunayevska, *Human Rights in Childbirth National Report : Ukraine*, October 2016.

<sup>18</sup> HRIc, *Europe Summit Report: Croatia*.

<sup>19</sup> Even though the Italian Supreme Court has expressed the non-validity of this practice. E., Skoko and A., Battisti, *Italian Report for HRIc Europe Summit*, October 2016.

<sup>20</sup> Where sometimes women are asked to sign blank standard forms. Mame pentru Mame, *HRIc Europe Summit Report Romania*, 2016.

<sup>21</sup> J., Debrecéniová, M., Hlinciková, E., Hresanová, Z., Krisková, Z., Laffersová and M. Sekulová, *Systemic aspects of violations of women’s human rights in birth care provided in healthcare facilities in Slovakia*, 2016.

<sup>22</sup> February 2018 <https://www.who.int/reproductivehealth/intrapartum-care/en/>

interventions are performed based on the decisions of the medical staff. The focus tends to be more on the baby than on the mother. Therefore, we are denouncing the fact that the mother is regularly disregarded from the birthing process, whereas it would be beneficial for both the mother and baby to be seen as right holders on an equal basis.

The loss of legal capacity is recurrent in all countries where obstetric violence occurs. This kind of behaviour clearly shows a tendency of healthcare professionals to use their authority in order to coerce the will of the pregnant women, a tendency that is less present in their relations with other kind of patients. The reality is that violence in childbirth is first and foremost violence directed at women because they are women.

It is also important to denounce the way childbirth is perceived in many societies, generally those with the most medicalised environments. Pregnancy is not an illness and therefore it should not be treated like one by the medical staff. Giving birth is a deeply personal experience and there are as many childbirths as there are women giving birth. It is necessary for health professionals to communicate well with pregnant women rather than place their professional skills or scientific knowledge above the will of the mother. As it has been made clear in many reports, doctors and other health professionals have a culture of « expected compliance » and regularly use their status to overcome demands made by women.

Another consequence of the over-medicalisation, disrespect and abuse is that some women choose to give birth out of the hospital to ensure their rights are respected. Home births are not forbidden, however women do not always have access to an attended home birth by a health professional<sup>23</sup> or only under certain circumstances. In addition, they can also be punished if they are finally transferred to a facility in case they labour at home and be discriminated in terms of soft access to medical treatment.

Such differences do not respect the jurisprudence<sup>24</sup> of the European Court of Human Rights, which declared in 2010 that women have a human right to choose the circumstances in which they give birth. It is also interesting to note that in the Netherlands, while attended home births are legal and supported, less and less midwives are willing to attend such procedures due to a fear of legal prosecution<sup>25</sup>. Women should have the possibility to decide whether or not they want to give birth in a hospital or in another setting and should have access to, if it cannot be done at home, more respectful and women-centred institutions such as birth centres.

The lack of consent is, in the majority of cases, the result of a lack of complete information given to the pregnant women about the choices that are presented to them or the procedures they are going to be subjected to. The information given is sometimes purposely incomplete, difficult to understand, or given in a situation where it is difficult for the mother to really concentrate on what is said to her or to be able to take the time to make a choice. In some cases, no information is given at all.

The absence of effective information is detrimental because talking about and explaining the procedure to the mother and what is to happen would comfort her and make her feel as she is taking part in what is happening to her, and would reduce the percentage of treatments performed without consent. When women are informed and give birth in a respectful environment they will feel safe and be able to contribute more effectively to the birth process, thereby reducing the need of medical interventions. An intervention can interfere with the natural process of the physiological birth and

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<sup>23</sup> In the Czech Republic, it is forbidden to give birth at home with the support of a midwife. The European Court of Human Rights in the case *Dubská and Krejzová v. Czech Republic*. considered that the legislation did not violate art. 8 of the European Convention of human rights.

<sup>24</sup> European Court of Human Rights. *Tzernovszky v. Hungary*. 2010. Application no. 67545/09, European Court of Human Rights. Ref type: case

<sup>25</sup> Dutch National Report for HRIC Summit, 2016.

provokes a number of medical interventions, which are not always needed. Such interventions are only justified case of high-risk pregnancies or complications but not for every birth.

## **b) The right not to be subjected to violence**

The right of women to not be subjected to violence is present in multiple legal sources: the Universal Declaration of Human Rights<sup>26</sup>, the European Convention on Human Rights<sup>27</sup>, the Declaration on the Elimination of Violence against Women adopted by the UN General Assembly in 1993, which promotes the right « *to liberty and security of person* », but also the right « *to not be subjected to torture, or other cruel, inhuman or degrading treatment or punishment* »<sup>28</sup>. The Council of Europe Convention on preventing and combating violence against women and domestic violence (the so-called Istanbul Convention) also aims to « *protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence* »<sup>29</sup>.

Once again, Article 1 of the UN Declaration on the Elimination of Violence against Women gives a good description of what can be considered as such: « *any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life* ».

One of the biggest challenges in the fight to ensure that obstetric violence is recognised as gender-based violence is that this violence is still perceived as a sort of « necessary evil » or simply the result of exaggeration by hysterical women, even though it is evident that obstetric violence is the result of discrimination against pregnant women in health care systems.

Obstetric violence can be divided into two sub-categories: physical and psychological.

Physical obstetric violence includes: unnecessary procedures such as episiotomy, amniotomy, breaking the membranes without consent, fetal heart monitoring, excessive vaginal examinations or C-section, unjustified induction or augmentation of labour, non-consented care (including sterilizations), the withholding of pain medication, painful suturing of perineal tears without proper anaesthesia, preventing women from eating and drinking during labour, restraining or the freedom of movement and/or forcing the position of the mother, the use of the Kristeller manoeuvre, slapping and handcuffing.

Psychological obstetric violence can take many forms. The more recurrent ones are the absence of consideration for the intimacy of giving birth, forced routine pubic shaving, routine separation of women from their new-born babies, judgmental or discriminatory comments or even threats, intimidation and verbal abuse.

An act does not necessarily have to be done with the intention of causing harm in order to be physical or psychological violence. Many of these violent treatments can be avoided if the medical staff receives proper training on how to interact with pregnant women or how physiological birth happens. They often lack knowledge about the natural process of giving birth that does not require systematic interventions by a health professional but only supervision and support when necessary. The transformation of « natural births » to over-medicalised ones is also the result of the commercialisation of healthcare.

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<sup>26</sup> Universal Declaration of Human Rights (1948).

<sup>27</sup> European Convention on Human Rights (1950).

<sup>28</sup> Article 3, points (c) and (h), Declaration on the Elimination of Violence against Women (1993).

<sup>29</sup> Article 1, point (1;a), Council of Europe Convention on preventing and combating violence against women and domestic violence (2011).

Whether it be physical or psychological, as most of the time they are connected, such violence has a long-lasting impact on mothers, it is proven that it can result in a negative impact on the sexual life of the victim, multiply the risks of postpartum depression, or can even lead to PTSD<sup>30</sup>. The fact that in the healthcare systems of some of the more (so-called) developed countries it is possible for a women to leave a hospital with the same mental trauma than a soldier coming back from war, and that the governments of those same countries still fail to recognize the reality and gravity of the situation, is one of the more blatant violation of human rights that can be encountered on democratic, war-free societies.

### c) The right to intimacy

For the purpose of our report, we consider the violation of intimacy as the act of giving birth in conditions where a woman is unwillingly exposed to other people. Such cases are recurrent, particularly in University hospitals. It can also exist when several women are forced to share a single room without proper separations, that the delivery is taking place in a room open on a hallway, or even in the hallway itself, or that there is more staff than needed assisting at the birth for teaching purposes.

Violating the right to intimacy is not fundamentally different from psychological violence, with which it shares the same traumatic consequences for mothers. We nonetheless feel that it is important to address this issue specifically since a woman's right to intimacy during birth has been recognized by the European Court of Human Rights in the of *Konovalova v. Russia* case<sup>31</sup>.

In this case, the applicant claimed that the presence of medical students during her labour was a violation of Article 8 of the European Convention on human rights<sup>32</sup>. The Court recognized the breach of that article saying that *"In light of the above, the Court finds that the presence of medical students during the birth of the applicant's child on 24 April 1999 did not comply with the requirement of the lawfulness of Article 8 § 2 of the Convention, on account of the lack of sufficient procedural safeguards against arbitrary interference with the applicant's Article 8 rights in the domestic law at the time"*<sup>33</sup>.

This ruling is very important and innovative since it is one of the rare occasions in which an international court has recognized what can be considered as obstetric violence being a violation of a woman's human rights.

### d) Right to be protected by one's government

As we will see in this section, one of the most worrying parts of the obstetric violence issue is the fact that the European States do not seem eager to recognise the situation or act on it.

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<sup>30</sup> Post Traumatic Stress Disorder. It appears in this study *Childbirth Induced Post-traumatic Stress Syndrome: A Systematic Review of Prevalence and Risk Factors* Sharon Dekel, Caren Stuebe and Gabriella Dishy 2017 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5387093/>

<sup>31</sup> European Court of human rights, case of *Kolonova v. Russia*, 9 October 2014.

<sup>32</sup> "1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

<sup>33</sup> European Court of human rights, case of *Kolonova v. Russia*, point 49.



This lack of political will is in direct violation of many conventions and declarations. For instance, article 5 of the Council of Europe Convention on preventing and combating violence against women and domestic violence, which most European States have ratified establishes that States shall *“refrain from engaging in any act of violence against women and ensure that State authorities, officials, agents, institutions and other actors acting on behalf of the State act in conformity with this obligation”*, and *“take the necessary legislative and other measures to exercise due diligence to prevent, investigate, punish and provide reparation for acts of violence covered by the scope of this Convention that are perpetrated by non-State actors”*<sup>34</sup>.

The UN Declaration on the Elimination of Violence against Women also stipulates that States shall *“exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons”* and *“Develop penal, civil, labour and administrative sanctions in domestic legislation to punish and redress the wrongs caused to women who are subjected to violence; women who are subjected to violence should be provided with access to the mechanisms of justice and, as provided for by national legislation, to just and effective remedies for the harm that they have suffered; States should also inform women of their rights in seeking redress through such mechanisms”*<sup>35</sup>.

On a more general scale, the Universal Declaration of Human Rights gives the right to everyone to *“an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law”*<sup>36</sup>.

As we have mentioned before, most of the data (surveys, reports, testimonies, jurisprudence) on the subject comes from actors of the civil society who do not have the same human and economic resources as their governments. The most notable exception is the case of France where the *“Haut Conseil à l'égalité entre les femmes et les hommes”* has put out a ground-breaking report<sup>37</sup> which thoroughly analyses the French situation and gives many useful recommendations.

Therefore for other countries, there is a lack of official data on cases of disrespect and abuse in childbirth, which tends to hide the issue from public scrutiny and therefore limits, in a kind of vicious circle, the possibilities that the countries feel the pressure to address the issue.

Still there are countries that have adopted guidelines or laws on how to interact with pregnant women in the context of perinatal care. We can give the example of Poland<sup>38</sup> with the 2012 Regulation of the Ministry of Health that introduced standards on medical treatment when providing perinatal care to women during the period of physiological pregnancy, physiological childbirth, postpartum and newborn care (the so-called the standards of perinatal care).

We affirm that the adoption of such legal instruments is rarely followed by effective implementation, monitoring or sanctions. Governments all too often consider that regulating a bad practice is enough to make it disappear, which has been proven wrong. Medical Practice and protocols in hospitals should change and that requires more than regulations.

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<sup>34</sup> Council of Europe Convention on preventing and combating violence against women and domestic violence - Istanbul, 11.V.2011.

<sup>35</sup> Article 4, point (c) and (d), Declaration on the Elimination of Violence against Women ( A/RES/48/104 ) - 20 December 1993.

<sup>36</sup> Article 8, Universal Declaration of Human Rights (1948).

<sup>37</sup> Les actes sexistes durant le suivi gynécologique et obstétrical Des remarques aux violences, la nécessité de reconnaître, prévenir et condamner le sexisme. Haut Conseil à l'égalité entre les femmes et les hommes - Rapport n°2018-06-26-SAN-034, voté le 26 juin 2018.

<sup>38</sup> Childbirth with Dignity Foundation, Report: Perinatal Care in Poland, 2016.

The lack of an official body enforcing Law implementation is usually accompanied by a lack of legal redress. To understand why so few cases are introduced in front of a civil or criminal court, it is important to remember that the complaints of women are first submitted internally at the hospital facility or the national authority or agency competent to hear these cases.

The way hospitals and other institutions react to obstetric violence complaints made by women against their staff is often problematic. Numerous reports indicate not only a reluctance of the litigation services to start an inquiry<sup>39</sup>, but also the loss or alteration of the medical records<sup>40</sup>, or procedures leading to no result<sup>41</sup>. Those kind of bad practices imposed onto women, who try to make their complaints heard at a moment of vulnerability, as the trauma of the violence is generally recent, not only tend to discourage any further initiative to have the violation of the rights recognised, but also constitute another form of psychological violence (institutional violence), which adds to the existing one.

But even when mothers have the will to bring their claims in front of a State jurisdiction, the reactions are rarely positive. For instance, in France there are no examples of successful actions at these courts [Criminal, Administrative or Civil courts] due to the lack of consent or information in the context of childbirth<sup>42</sup>. A notable exception is the decision of the UK Supreme Court which produced a milestone judgment on informed consent in the *Montgomery v. Lanarkshire Health Board* case (2015) where the Court held « that clinicians must adopt a woman-centred approach during pregnancy »<sup>43</sup>.

Another obstacle of justice in favour of the women is the lack of information accessible to them. Women are rarely aware of the information concerning their rights when they are giving birth, which impedes the realisation that the medical procedure was in fact illegal. They also lack information about the following steps that can be done to denounce those illegal procedures<sup>44</sup>.

The possibility to submit a claim on this topic to an independent ombudsperson is not an option in many countries, which is deplorable because it would allow women to be heard by someone impartial without the expenses and the dilemma of filing a legal case.

The intervention of state agents, most notably police officers, in cases of obstetric violence is even more problematic. Such interventions have been observed in cases concerning pregnant detainees<sup>45</sup>

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<sup>39</sup> For instance, Romania where « the hospital reluctantly starts an inquiry procedure and decision-making which lacks transparency and is more than often just an effort to falsify IC forms and cover errors from medical staff ». Mothers for Mothers, HRIC Europe Summit Report: Romania, 2016.

<sup>40</sup> For instance, Germany where « info in hospital documentation [...] is often tempered with ». German Guideline Questions for National Reports for HRIC Europe Summit, 2016.

<sup>41</sup> For instance, Ukraine where « the intra-doctoral and intra-hospital loyalty is extremely high [...] and women have practically no chance to uphold their rights by approaching a head doctor with a complaint about his subordinate ». S., Demianova-Ponomarenko, O., Vishkina, A., Salnykova, J., Shushaiilo and A., Dunayevska, Human Rights in Childbirth National Report : Ukraine, October 2016.

<sup>42</sup> Collectif Interassociatif Autour de la Naissance, Informed consent and refusal: France report for HRIC Summit, 2016.

<sup>43</sup> Birth rights, HRIC report, 2016.

<sup>44</sup> For instance, even if the possibility to present a complaint to the CEDAW is a good initiative it would be interesting to study how many women, who have or have not suffered from obstetric violence, know of the existence of the Committee. This absence of clarity probably explains the few cases of obstetric violence brought to the CEDAW.

<sup>45</sup> See for instance the case *Y.F. v. Turkey* (22 July 2003) where the ECHR concluded to a violation of Article 8 of the convention.

even in cases of women temporarily deprived of their liberty for not following medical advice and being forced to an unnecessary C-section. Such a case was recently reported in Spain<sup>46</sup>.

To end this section we would like to point out that very few countries have medical guidelines on what is categorized as a normal and respectful birth with low obstetric risk. We can include Belgium<sup>47</sup>, Spain<sup>48</sup>, Portugal and the United Kingdom<sup>49</sup>.

### e) Freedom from discrimination

The last human right we chose to point out that has been violated by obstetric violence is also the most important as it is at the center of the problematic issue. In other words, women suffer from obstetric violence, which is a form of discrimination, simply because they are women.

Giving birth is a feminine specificity but it would be wrong to assume that the recurrent cases of violence against women in a medical environment are due to the fact that obstetric procedures are inherently more violent due to the specificity of the act of giving birth. The truth is that obstetric procedures are made more aggressive as they only involve women. For the same reason, the notion of consent disappears as soon as a woman enters a health institution for prenatal, childbirth or postpartum care.

We are therefore in the presence of a systemic violation of the human rights of pregnant women.

Ironically, the fight against discrimination is at the centre of all legislation protecting human rights, notably the ones ensuring the protection of women. Yet there is still little response from governments on the issue of obstetric violence.

The Universal Declaration of Human Rights states that *“All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination”*<sup>50</sup>. Similarly, the UN Declaration on the Elimination of Violence against Women recalls that women are entitled to *“be free from all forms of discrimination”*<sup>51</sup>.

The UN Convention on the Elimination of Discriminations against Women (CEDAW) is more precise in article 12 when it proclaims that *“States Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”*<sup>52</sup>.

An emphasis should be put on the prohibition of discrimination of the European Convention on Human Rights not only because the text is specific in itself<sup>53</sup> but also because of a *jurisprudence* of the

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<sup>46</sup> Acta Sanitaria, Violencia obstétrica extrema en Oviedo (España), en el Hospital Central de Asturias, 27 April 2019. <https://www.actasanitaria.com/violencia-obstetrica-extrema-en-oviedo-espana-en-el-hospital-central-de-asturias/>

<sup>47</sup> Guideline relative to low risk birth - KCE reports 139C.

<sup>48</sup> Clinical Practice Guideline on Care in Normal Childbirth - Ministry for health and social policy.

<sup>49</sup> Intrapartum care for healthy women and babies - National Institute for Health and Care Excellence.

<sup>50</sup> Article 7, Universal Declaration of Human Rights (1948).

<sup>51</sup> Article 4, point (e), Declaration on the Elimination of Violence against Women ( A/RES/48/104 ) - 20 December 1993.

<sup>52</sup> Convention on the Elimination of All Forms of Discrimination against Women (1979).

<sup>53</sup> Article 14 *“ The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status”*.

European Court of Human Rights, which recognised that in the case of domestic violence, a violation of Article 14 can take place in conjunction with Article 2 (right to life) and Article 3 (Prohibition of inhuman or degrading treatment).

Such jurisprudence has been established in cases of general and discriminatory judicial inaction<sup>54</sup>, a lack of action from authorities that amounted to the condoning of violence against women<sup>55</sup> or a legislative framework not guaranteeing enough protection<sup>56</sup>. All those cases only concern situations of domestic violence but it is impossible to affirm that, should the right case end up in front of the Court, that it could not apply that jurisprudence to obstetric violence.

The probability of a woman to suffer from discrimination increases when it intersects with other causes of discriminations like race, ethnicity, etc. These women are usually in positions of vulnerability and more prone to suffer from discrimination. For instance, in the US, the Centers for Disease Control and Prevention<sup>57</sup> reported that African-American, Native American and Alaskan Native women are about three times more likely to die from causes related to pregnancy, compared to white women<sup>58</sup>. Discrimination can be economically or racially motivated: a good example is the decision of a Hungarian Court which recently ordered a hospital to cease the practice of charging parents of pregnant women for specific clothing requirements in the birthing rooms. This practice was discriminatory against mothers living in poverty, notably women of Roma origin who therefore had to give birth alone without the father, leaving them even more vulnerable and exposed to the risk of abuse and harassment by racist medical practitioners<sup>59</sup>.

The 2013 study from Birthrights UK on disabled women also showed that they faced particular human rights issues in maternity care. Bournemouth University was commissioned to undertake quantitative and qualitative research in this area. Its final report<sup>60</sup> was published in March 2018. A survey of women with physical or sensory impairment or long term health conditions highlighted that these women received inadequate information about their choices more often than other women. They were also unhappier with the availability of pain relief, felt they had less choice and control over their birth experiences, and that their rights were rarely respected.

As a conclusion of this section, we would like to once again emphasize how critical it is for governments around the world to admit that a human rights violation crisis based on discrimination has been occurring within their countries for too many years and that they need to act accordingly to put an end to it.

#### **4) Response to the specific questions**

Since we have repeatedly mentioned our key points throughout our report we will, in the place of a conclusion, try to briefly answer the four questions of the UN Special Rapporteur on violence against women.

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<sup>54</sup> *Opuz v. Turkey*, 9 June 2009.

<sup>55</sup> *Eremia and Others v. the Republic of Moldova*, 28 May 2013. In its decision the Court cited the findings of the United Nations Special Rapporteur on violence against women. See also *Balsan v. Romania*, 23 May 2017.

<sup>56</sup> *M.G. v. Turkey*, 22 March 2016.

<sup>57</sup> Centers for Disease Control and Prevention, *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, 07 May 2019.

<sup>58</sup> See also: *Huge Racial Disparities Found in Deaths Linked to Pregnancy*, New York Times, 07 May 2019.

<sup>59</sup> European Roma Rights Center, ERRC ends discriminatory hospital charges affecting romani mothers, November 2018.

<sup>60</sup> <http://www.birthrights.org.uk/wordpress/wp-content/uploads/2018/03/Birthrights-Bournemouth-Liverpool-Human-Rights-and-Dignity-Experiences-of-Disabled-Women-during-Pregnancy-Birth-and-Early-Parenting-1.pdf>

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;*

Cases of disrespect, abuse and violence against women during reproductive healthcare are widespread globally<sup>61</sup>. They are omnipresent, systemic and recurrent in all the countries included in this report and they concern both developed and developing countries. The fact that a country is over-medicalised does not mean that there is no obstetric violence but rather that the malpractices are different than those observed in poorer countries. The objective of fighting maternal and child mortality cannot be used as an excuse to violate human rights during the perinatal period. Such HR violation can have long-lasting consequences on the wellbeing of mothers and children. In the present, governments have generally shown a lack of response to this issue by not collecting official data or failing to change the legal framework and system to promote respectful maternity care.

We are including in annex 1, a compilation of testimonies of women as victims of obstetric violence in several countries.

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

The disrespect of informed consent is the most common human rights violation during reproductive healthcare. A great majority of national healthcare systems do not provide enough information to pregnant women on their rights, which is the basis for informed consent.

For more information, please see section 4a of this 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 a vicious cycle, since the problem of obstetric violence is not officially recognized in many states, very few women end up bringing their cases in front of a judge due to a lack of information on their rights (to understand which rights could have been violated) and on how to seek redress.

Ombudspersons are rarely competent by national laws to take care of these cases, and in some countries (e.g. Italy) they cease to exist. In addition, usually there are other important issues, which demand their attention and make it difficult to make the institutions responsible for any wrongdoing.

The possibility to present an individual complaint to the CEDAW Committee when obstetric violence has occurred is high. However, the cases the committee has reviewed until now are predominately focused on domestic violence. Many women do not have the financial resources or available knowledge to submit their case to the Committee after having brought the case to the national level. The lack of clarity concerning this leads to explain the limited amount of cases of obstetric violence brought to the CEDAW Committee.

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<sup>61</sup> The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review Bohren MA, Vogel JP, Hunter EC Lutsiv O, Makh SK, Souza JP, Aguiar C, Saraiva Coneglian F, Diniz AL, Tunçalp Ö, Javadi D, Oladapo OT, Khosla R, Hindin MJ, Gülmezoglu AM. 2015

Additional information relevant to this question can be found in different sections of this submission including those on the right to not be discriminated, protection from Government and protection against violence.

*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;*

European countries all have laws and policies to address violence against women. This does not mean they are efficient and that they address the specific issue of violence within childbirth.

WHO published guidelines on intrapartum care in February 2018, but they have yet to be implemented. Guidelines on respectful birth are not very common even though some countries do have guidelines on normal birth, pregnancy and C-sections such as the United Kingdom, Portugal, Spain and Italy. Some countries are also currently working on those guidelines: e.g. Hungary is developing guidelines on family-friendly births and Germany is working, for the first time, on guidelines for vaginal birth at term, which will be published next year.

The fact that those guidelines were published does not automatically improve the situation of mothers: there is a general lack of implementation and oversight of those guidelines as obstetric violence is not yet recognized as a human rights violation.

It is absolutely necessary to develop a clear definition of what constitutes obstetric violence in order to include this category of violence within the notion of violence against women. This will allow the courts to apply the general laws on violence against women when examining cases where women have suffered this type of violence.

## **5) Recommendations**

Considering all the above, we urge Governments and all stakeholders to:

1. Support research and data collection in order to measure the prevalence of obstetric and gynaecological violence during pregnancy, childbirth, and postpartum and investigate its impact on the health and autonomy of women and their children;
2. Adopt national strategies and guidelines with the involvement of maternity healthcare users in the decision-making process, at both the individual and policy levels;
3. Implement accountability and transparency policies in healthcare facilities that allow users to make informed decisions;
4. Support the choices of women on birth settings (including homebirth and midwifery-led birth centres), as part of a regular offer within maternity care;
5. Set up mechanisms and conduct surveys (from national health authorities) involving mothers to report their childbirth experiences without a stigma or fear;
6. Establish by law a system of resolutions and monetary compensations for violations during pregnancy, childbirth and postpartum;
7. Design educational programs on the respect of human rights in childbirth for both healthcare providers and users, starting from schools to universities;

8. Include women and mothers in educational programs aiming at teaching healthcare providers how to treat a childbearing woman and babies with dignity and respect.
9. Support midwives by increasing their numbers by setting up studies allowing for direct access to this profession in all countries.
10. Guarantee in any case that human rights defenders will be able to work and provide their support without fear of retaliations, harassment or undue hindrance.
11. Inform women about their human rights in childbirth in the country where they are giving birth and train them to understand the process of physiological birth and the interventions which have a positive impact based on science. For instance, by disseminating the Mother baby rights from the [International childbirth initiative](#).
12. Identify the best practices when fighting obstetric violence in hospital facilities such as the support of women during pregnancy and childbirth through trainings and the use of birth plans that need to be signed by the health professionals.
13. Develop a clear definition on what constitutes obstetric violence as a category of Violence against women so it can be used when examining court cases on violence against women.

## About MMM

*Make Mothers Matter (MMM) is an international NGO created in 1947 to raise the awareness of policy makers and public opinion on the contribution of mothers to development and peace. its mission is to advocate for recognition and support of mothers as changemakers for a better world. MMM especially promotes the universality and importance of the economic, social and cultural role of mothers, based on their skills and responsibilities as primary educators of their children.*

*MMM has no political or religious affiliations, and thus transparently voices the concerns of mothers and acts at an international level to influence policy and public opinion in order to bring about positive changes in the lives of mothers. Working for and with mothers by involving them in development projects, has beneficial effects on their children, their families and more broadly on society. MMM has permanent MMM representatives at the United Nations (General Consultative Status), UNESCO and the European Union.*

More information on [www.makemothersmatter.org](http://www.makemothersmatter.org)

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## Annex 1: Selection of testimonies

### Croatia<sup>62</sup>

*“October 1st, 2015. 9 weeks pregnant. There's no heartbeat. Scheduled for a curettage. Sisters of Charity Hospital Zagreb. Spent 5 hours in the waiting room looking at happy mothers-to-be. Curettage performed without anaesthesia, for the second time that year. Two months later I went to a private doctor and found out my uterus had torn.”*

*“August 2015., I had a miscarriage at 9 weeks (1st pregnancy). Curettage was performed without anaesthesia by a doctor in Petrova hospital in Zagreb under the guise "This is just an examination". As I laid on the gynaecological table, the torture began. I was screaming in pain, I wanted to gather my legs, but there were two nurses holding me down. They were stronger than me.”*

*"I was crying while the doctor was taking samples and he said "you didn't cry while having sex so just shut up now.”*

### France<sup>63</sup>

*« I wanted to give birth without the epidural, but the midwife succeeded in scaring me, telling me I would feel like "I was hit by a car", that "I would feel like my bones were being broken" and that" I would want to die. »*

*« The medical staff took my birth plan very badly, they even laughed at me. »*

*« The doctor insisted on giving me Pitocin, even if we refused... We are more vulnerable during labour, I submitted. I feel guilty now. »*

### Poland<sup>64</sup>

*« The doctor ridiculed my birth plan... he said that he would put it into frames ».*

*« When I didn't know whether I have milk or not, a midwife, who wanted to show me that it is dripping, pinched my teat so hard that it nearly was torn off. I was depressed and confused when the next day I was told that I starve my baby because she loses weight ».*

### Ukraine<sup>65</sup>

*« I was asked to fill out a long questionnaire that gave me a choice of many different medical procedures and tests. At the same time, a chief midwife and the antenatal clinic head behaved in a pretentious and threatening manner after I refused a vaginal exam and an ultrasound... The antenatal clinic head as she learned of my refusal from an ultrasound (especially given that it is free) has offered me psychological and psychiatric help. She has also invited an OBGYN and 2 nurses and birthing clinic head for them to talk to me ».*

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<sup>62</sup> HRiC, Europe Summit Report: Croatia.

<sup>63</sup> Collectif Interassociatif Autour de la Naissance, Informed consent and refusal: France report for HRiC Summit, 2016.

<sup>64</sup> Childbirth with Dignity Foundation, Report : Perinatal Care in Poland, 2016.

<sup>65</sup> S., Demianova-Ponomarenko, O., Vishkina, A., Salnykova, J., Shushaiilo and A., Dunayevska, Human Rights in Childbirth National Report: Ukraine, October 2016.



«At the check-up my cervix was artificially dilated, it was very painful, during the following night it has fully dilated and contractions started, but no urge to push yet. So they gave me oxytocin, as I was still unable to push they've cut me, did not offer me any vertical position, just pressed the baby out. All this has happened during 3.5 hours... I still would like to hear from them why did I need all that; wasn't it all unnecessary? And after the birth the baby has got a diagnosis due to all this stimulation...»

«They constantly checked my dilation – afterwards I had a feeling as if I were raped by 5 people. They also cut my perineum, JUST IN CASE, so that there are no tears».

“They told me that since I agreed for one intervention (for which there were prerequisites) I had to agree to other interventions as well. “Because this is our protocol”, although there were no reasons for other interventions”.

#### United Kingdom<sup>66</sup>

‘Often you see the word offer, induction was offered, something was offered, but it’s not offered really, I mean if there’s an offer there’s an assumption that someone has an option to say “ooh, thank you very much but no I won’t thanks”, whereas actually that’s not really what’s meant at all.’ Polly

‘Women are made to feel so terrible if they don’t conform, and they’re talked about within the staff room, you know “I can’t believe she hasn’t done that” or “I can’t believe she has done this”. If you don’t conform you are in a way stereotyped into being a bad woman.’ Student midwife

#### The Netherlands<sup>67</sup>

« During the caesarean I panicked. Instead of calming me down, I was anesthetized completely. I woke up a few hours later, alone and scared. I didn’t know what happened. The first few hours with my twins were taken from me, and I will never get them back. »

« I am 38 weeks pregnant when I tell my new gynaecologist, I don’t want a caesarean at 41 weeks. The response was: “afterwards you will sit opposite us in the courtroom, discussing your dead child and we will have to say ‘Madam, was stubborn””. I can’t get this image of my dead baby girl out of my head. »

« After examining me vaginally, they told the doctor in training: ‘all done, now you can feel for a moment’. When I told them I really didn’t want them to, because one was more than enough. They said: ma’am, they have to learn somehow” and I felt another hand go in. Then he told a second one: “your turn”. I yelled crying: “enough!” and he said: “it is always the women making everything so difficult.”. »

<sup>66</sup> Birthrights, HRiC report, 2016.

<sup>67</sup> Stichting GeboorteBeweging report on obstetric violence for the U.N. Special Rapporteur.