01 Juin 2022

Make Mothers Matter

Answers to the questionnaire

From the Special Rapporteur on the theme "Racism and the right to health"

1 – What are the main ongoing manifestations of racism, and related forms of discrimination enabled by racism that may be prevalent in your country in the area of the right to health broadly including in underlying determinants of health, health outcomes and access to health care?

As an NGO overseeing the role of women in society, our answers will concentrate on racism and maternity, through two indicators: women's mortality during childbirth and obstetric violence.

Maternal Mortality around childbirth

We will not focus on one country but will take a transversal approach, looking at this situation in many developed countries.

"*Women are not dying because of untreatable diseases. They are dying because societies have yet to make the decision that their lives are not worth saving.*"
Professor Mahmoud Fathalla, President of the International Federation of Obstetricians and Gynaecologists

The majority of these deaths and disabilities could be avoided by medical follow-up during pregnancy and skilled attendance during birth. Maternal mortality is a significant indicator of the quality of a health system in any country – and of the status of women in society.

According to the World Health Organization (WHO), Sub-Saharan Africa and South Asia account for around 80 % of maternal mortality. This is a sign of the inequalities in access to health care services and highlights the gap between rich and developing countries[1].

In developed countries, maternal mortality rates are on average considerably lower (1 woman in 6500 against 1 woman in 37 in Sub-Saharan Africa)[1]. On the face of it, this appears to be characteristic of a society offering quality health services.

However, in many developed countries (France, Belgium, Canada, USA…), we find that maternal mortality rates hide disparities. Indeed, women from minority backgrounds linked to immigration or indigenous populations have a higher mortality rate. In its report, WHO underlines: "although progress has been accomplished in the reduction of maternal and child mortality, the fact remains that glaring inequalities persist, based on geography, gender and ethnicity."

Maternal mortality is generally well documented. However, the mortality rate taking into account the racial origin of the mother does not exist officially in recurrent statistical data, but rather in occasional studies conducted on small groups of women.

[1] WHO, « Mortalité maternelle », (19 Septembre 2019). https://www.who.int/fr/news/item/19-09-2019-more-women-and-children-survive-today-than-ever-before-un-report

Obstetric violence[2]

In addition to maternal mortality, the phenomena that we combine under the term of "obstetric violence" are also indicative of a form of racism. In 2019, the UN dedicated a special report to the issue of obstetric violence and recognized it in some cases, as Violence Against Women, and in others, as Human Rights Violations.

Obstetric violence can be classified into several categories[3]:
- Pathologization: abuse of medication and triggering techniques
- Dehumanisation: psychological violence, lack of listening, inappropriate words
- Lack of free and informed consent on the medical procedures performed: episiotomy, oxytocin injection, cesarean section
- Precedence of protocols over the patient's needs: continuous monitoring, non-respect of the patient's wishes to give birth in this or that form

Obstetric violence has an impact on the future life of mothers: impact on their health (incontinence, difficulty in moving, etc.), or psychological (loss of esteem, self-confidence, etc.). It also has an impact on the future of their children.

Discrimination against certain communities amplifies the frequency of obstetric violence. They take the form of inappropriate comments, marked dehumanization, diminished quality of care and a disregard from the nursing staff, or even openly racist remarks such as homogenization of a group of people and use of stereotypes. For example: "These Haitians, why are they all screaming? ".

The notion of obstetric violence and its awareness is recent. Official statistics in this area are scarce. Statistics taking into account racial, ethnic or geographical origin are even scarcer. The only accessible data comes from occasional studies carried out by sociologists, healthcare teams or others.

2 – Who are the most affected people and why? Please describe existing disparities in the provision of and access to health services that affect people of different racial and ethnic origin, descent as well as other groups, such as migrants. The lack of data, analysis or health indicators in this regard may also be reflected.

Communities affected by these discriminations in childbirth care and by a higher mortality rate:

Disparities in the conditions for women in childbirth, obstetric violence and mortality rates are particularly noticeable in the following populations:
- Mothers from immigrant origins, recent or not. For example, population of African origin in the USA and Canada, Hmong minority in the USA, population of Turkish origin in Belgium, sub-Saharan in France
- Indigenous minorities like Inuit in Canada, Native American in the USA, Sami population in Norway[4]
- Refugees
- More generally, illiterate women and /or those living in modest conditions

[2] - United Nations, General Assembly, Report of the Special Rapporteur on violence against women, "A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence" - Assemblée Générale de l'ONU : A/74/137- (11 Juillet 2019).

[3] - Catherine Novello-Vautour, « Discriminer le miracle de la vie : la violence obstétricale chez les personnes noires et autochtones dans les institutions de santé au Canada », (Septembre 2021).

[4] - *Discrimination of the Sami population, the national minorities and migrants in Norway/Diskriminering av samer, nasjonale minoriteter og innvandere i Norge*

Thus, in Canada, women of African origin are more at risk of having a premature birth: 8.9/1000 for black women versus 5.9/1000 for white women[5]. In Canada, black women are also more at risk of enduring discriminatory treatment, as well as: not having access to alternative birthing methods; being isolated and ignored by medical personnel; not being informed of the process, of their rights and of the medical procedures; having their companion or spouse treated disrespectfully by the medical personnel; and enduring racism.

In the United States, African-American women are three times more likely to die during childbirth than Caucasian women.[6] In New York, the risk is 8 times higher. The US Department of Health estimates that half of the deaths of black women could be avoided if they were treated in hospitals frequented by white women. A movement was born alongside *Black Live Matters*: "Black birthing lives matter" as well as the "Black Maternal Health Week", chaired by US President Biden. Kamala Harris declared: "It's not about education or socio-economics. There is an implicit bias in our health care system." The United States is the only country where maternal mortality has been rising steadily for the past 20 years (+27% between 2000 and 2014, when the figure reached 28 deaths per 100,000 births).

In France, a study conducted between 2013 and 2015[7][8] shows that a mother, living in France but born in sub-Saharan Africa, is three times more likely to die from pregnancy or childbirth than a woman born in France.

In Norway, women with low incomes, those with a limited level of education or immigrant women, are more likely to be victims of obstetric violence[9].

Why are these populations more at risk of perinatal mortality and obstetric violence?

For mothers:
- Language barriers for immigrant women: difficulties communicating with the care team, expressing what they feel, what they want, and asking questions
- Degraded health conditions even before the start of pregnancy: poor diet, poor health monitoring of other diseases (hypertension, diabetes, cardiovascular disease, obesity, etc.) - These poor health conditions are also indicative of precarious living conditions and unequal access to a decent healthcare system
- Lack of information on their rights, medical procedures
- Atmosphere of mistrust against the host country's medical system for recently immigrant populations

Health systems are clearly involved at different levels:
- Infrastructures of unequal quality: obsolete equipment, presence or absence of a neonatal emergency service or resuscitation service – this situation may be linked to a deliberate choice of investments by the city, to public services with limited financial means
- Access to infrastructure - either by a lack of:
    - means of transport for the household concerned
    - the location / residence of the mother – this pertains in particular to indigenous women living in isolated geographical areas

[5] - Katherine Novello-Vautour, (2021) - Mitchell & Herbert, (2014) – Patychuk, (2011 ; Enang (1999)
[6] - Emission Arte Reportage, « USA : discrimination à la maternité », (avril 2022).
[7] - 6è rapport de l'Enquête nationale confidentielle sur les morts maternelles (ENCMM), « Les morts maternelles en France : mieux comprendre pour mieux prévenir 2013-2015 », (6 janvier 2021).
[8] - *Revue européenne des migrations internationales*, Priscille Sauvegrain, « La santé maternelle des "Africaines" en Île-de-France : racisation des patientes et trajectoires de soins », (2012).
[9] - Henriksen et al.(2019). The Safe Pregnancy study - promoting safety behaviours in anternatal care among Norwegian, Pakistani, Somali pregnant women: a study protocool for a randomized controlled trial. BMC Public Health. 19:724 - http://doi.org/10.1186/s12889-019-6922-

- Care teams:
    - Lack of training to fight against stereotypes of racial origin on pregnancy and childbirth, therefore persistence of these stereotypes leading to many inappropriate words, and distorted decisions medical acts
    - Lack of training in cultural diversity in childbirth practices, non-knowledge by healthcare teams of the traditional practices of certain ethnic groups
    - Refusal of the mother to undergo different acts (forceps, epidural, childbirth in a lying position, etc.)
    - Lack of understanding of the mother's request linked to specific practices from their country of origin, their ethnicity: presence of members other than the father (shaman, douala, mother, etc.), or childbirth in a different position other than the occidental way
    - Quality of communication and listening. More generally, less respect for a mother of different racial origin, poor and illiterate

Overall, there is very little data on maternal health in maternity wards because in many countries racial data are not recorded in hospitals. This lack of data is an obstacle to the health system's fairness.