Case studies on obstetric violence: experience, analysis, and responses

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SAGE
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Acronym	Country
AT	Austria
BE	Belgium
BG	Bulgaria
HR	Croatia
CY	Cyprus
CZ	Czechia
DK	Denmark
EE	Estonia
EL	Greece
ES	Spain
EC	European Commission
EP	European Parliament
EU	European Union
FI	Finland
FR	France
DCC	Dutch Civil Code
DE	Germany
FIGO	Federation of Gynaecology and Obstetrics
HU	Hungary
IE	Ireland
IT	Italy
LV	Latvia
LT	Lithuania
LU	Luxembourg
MS	Member States
MT	Malta
NL	The Netherlands
OVO	Observatory of Obstetric Violence
PL	Poland
PT	Portugal
RO	Romania
SDG	Sustainable Development Goal
SK	Slovakia
SI	Slovenia
SE	Sweden
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations
WHO	World Health Organization

1 Introduction

The four Case Studies on the issue of obstetric violence in this volume were prepared to inform the development of a wider study on the topic, 'Obstetric violence in the European Union: Situational analysis and policy recommendations' by Patrizia Quattrocchi. This wider study was developed under the aegis of the SAAGE network, which draws together experts in gender equality to inform and support European Union level policy initiatives by providing expertise and knowledge on both relevant wide-ranging political issues and technical issues. The SAAGE network is coordinated by Fondazione Giacomo Brodolini S.r.l. SB (FGB SRL SB), an Italian independent research centre.

The general objective of the wider study is to inform the European Commission on the issue of obstetric violence in the European Union Member States and to contribute to the better understanding of this phenomenon and of current responses to the issue. It was undertaken in a context of growing public awareness of and concern about the issue, an established imperative for quality care at childbirth, and an understanding of obstetric violence as a violation of human rights and a form of gender-based violence and of institutional violence.

Obstetrics is the medical discipline that deals with pregnancy, childbirth and the post-partum period. Obstetric violence has emerged as a concern in policy, research and debate. The Council of Europe has defined it in terms of: inappropriate or non-consensual acts, such as episiotomies and vaginal palpation carried out without consent, fundal pressure or painful interventions without anaesthetic and of sexist behaviour in the course of medical consultations.[1]

The case studies were undertaken in the third quarter of 2022 by national experts in France (Virginie Rozée and Clémence Schantz), the Netherlands (Rodante van der Waal and Marit van der Pijl), the Slovak Republic (Barbora Holubová) and Spain (Stella Villarmea and Adela Recio Alcaide). They were deployed to further inform the wider study and its recommendations. The four Member States covered by the case studies were selected for their diversity of geographical location, social and cultural context, obstetric practices and healthcare systems and data availability.

The four case studies are based on a common guideline. They provide an overview of the issue as it manifests in these Member States and its causes and consequences, setting out and analysing the data and evidence available. They further examine initiatives taken by government and other stakeholders in these Member States to raise awareness, secure consideration of, and combat this issue. They extract learning from these initiatives and make recommendations for an improved response to the issue within the Member State.

1 Council of Europe (2019).

2 FRANCE by Virginie Rozée and Clémence Schantz

2.1 Executive summary

2.1.1 Background

In France, **violence in perinatal care** has been publicly addressed and discussed since **the 1970s**. But it really became a **public and political issue in the mid-2010s** when feminists began to report violence during childbirth on the internet. Denunciations and criticisms of obstetric and gynaecological care were disseminated on social networks and by the press. This growing digital and media mobilisation led a government body, the **High Council for Equality between Women and Men (HCE),** to **draw up a report** on obstetric violence to define, understand and counteract it. However, there is **no consensus in France about the concept** and **existence** of obstetric violence, especially within the medical community. This absence of consensus **limits initiatives** to prevent and combat it.

2.1.2 Aim

The overall objective of this case study is to provide an **overview of obstetric violence in France**, based on **scientific literature and grey literature** from associations, social networks and the press. The first aim is to identify and understand the empirical evidence available in France to capture and measure obstetric violence, its manifestations in the country and its root causes and consequences. The aim is then to identify existing initiatives in France from government, institutions and associations that have led to greater consideration and awareness of obstetric violence, both within the medical community and among the general population. Finally, this overview aims to formulate recommendations to better consider and combat obstetric violence in France.

2.1.3 Main findings

Research on the conditions and experiences of gynaecological and obstetric care **is scarce** in France and there is no statistical data measuring the obstetric violence. Its structural and subjective dimensions make it difficult to objectively define what obstetric violence is, to identify key variables relating to it and therefore to measure its extent. Hypothetically, **all women in France may be exposed to violence during pregnancy and childbirth**, but French **healthcare** is characterised by **inequalities and discrimination** that may affect some women more than others. Obstetric violence has mental, physical and social consequences that can compromise women's overall health.

Obstetric violence has become **more visible during the Covid-19 pandemic**.

To address obstetric violence, following two successive public cases denouncing violence by renowned gynaecologists, the **government convened the National Consultative Ethics Committee** (CCNE) to provide a better **framework for women's consent** during gynaecological and obstetric care. Other initiatives have also been implemented, such as the ***Maternys* label of facilities that respect the good treatment** and transparency of their practice during childbirth. However, the effects of such a label on women's actual experiences are still unknown. Birth centres have also been created. But their small number prevent them from meeting the social demand. In civil society, **two main associations** act against obstetric violence: **StopVOG**, which increases the public visibility of this violence by publishing testimonies on their social networks; and **CIANE**, which has become the most important association to support women and families who have experienced violence, including through legal proceedings. There are few initiatives to train and raise awareness among health professionals in France. Deconstructing the obstetric paradigm based on the notion of risk is very difficult. French obstetrics is highly medicalised and medical training is based on the assumption that childbirth is a risky medical event. Thus, in this context, this case study report recommends **more scientific studies on obstetric violence**, better **support for associations**, **national information campaigns** on women's rights during gynaecological and obstetric care, an increase in the number of birthing centres and a constructive debate on other birthing alternatives such as home births.

2.1.4 Summary and lessons learned

Obstetric violence is now a visible issue in the French public arena, mainly because of social networks and the media, as well as the ongoing mobilisation of collectives like StopVOG. However, it is a struggle for this violence to be recognised as a public health problem and to enter the political and legal agenda. To date, there is no law on the subject and there have been few condemnations.

However, initiatives have been put in place by the government, starting with **the HCE report in 2018** which for the first time addressed obstetric violence and made recommendations. Other initiatives have also been implemented to improve the conditions of gynaecological and obstetric care and avoid complications linked to a negative experience of childbirth: birth plans, early postnatal interviews, **birth centres and the *Maternys* label**. But their impacts and effects seem limited. Professional groups such as the French National College of Midwives (*Collège National des Sages-Femmes*, CNSF) and associations such as the CIANE are also developing initiatives to better consider, understand and therefore combat this violence. One initiative is establishing indicators to measure the extent of obstetric violence.

Nevertheless, the **challenges are still significant**. The **healthcare system** in France is in **crisis**, with "medical deserts" in particular. The closure of many maternity units limits women's choice and autonomy. And the current difficult working conditions of health professionals are not always compatible with efficient and quality gynaecological and obstetric care, both on a human and medical level. The lack of time in particular makes it difficult for health professionals to obtain the explicit consent of their patients, as explicitly required by the law. Beyond consent, the word 'violence' is often interpreted as having an intentional dimension, which is refuted by many health professionals. As a result, obstetric

violence is constantly questioned in French society, especially within the medical community. **This limits actions and initiatives** to combat it.

2.2 Overview

In France, violence in perinatal care has been an underlying social and political issue since the 1970s.[2] Indeed, the obstetrician **Frederic Leboyer developed the concept of painless births** for the wellbeing of the child, i.e. to reduce the supposed 'trauma of birth'.[3] Dr Michel Odent decided to put Leboyer's recommendations into practice and offered births with as little medical intervention as possible in her maternity hospital *les Pithiviers*. But this medical care of **painless childbirth has been highly criticised** by the 'defenders of **scientific obstetrics**'[4] as being unrealistic and too dangerous and by some feminists as being child-centred only (criticisms which will make Michel Odent leave *les Pithiviers* in 1985 and move to England). These initial controversies **prevented the practice from developing** further. In 2005, Michel Briex, gynaecologist-obstetrician, and the midwives of the maternity service of the Libourne hospital published in 'Chronicles of motherhood, the beautiful evil and the art of being born',[5] some women's narratives collected on the Gyneweb mailing list who reported aggressive behaviour, infantilisation and violence during childbirth. However, the testimonies have gone almost unnoticed by general public.

While in the 2000s, obstetric violence was already the subject of campaigns, scientific studies and even laws in some countries, mostly in Latin America,[6] it did not **become a public and political issue in France** until the **mid-2010s.** The issue of obstetric violence first appeared in feminist activist circles[7] and then was disseminated through social networks. In 2013, Marie-Hélène Lahaye, a Belgian feminist and jurist famous in France, launched her blog '*Marie accouche-là*' (Mary, gives birth there / now) to denounce the conditions of childbirth. Public claims then appeared on social networks, through in particular the hashtag *#PayeTonUtérus*. Launched on 19 November 2014, this hashtag collected 7 000 comments in 24 hours.[8] That same year, Agnès Ledig, author and midwife, publicly denounced a practice called 'le point du mari' (the husband's stitch),[9] a practice which consists, during the suture of a torn perineum or an episiotomy, in making an additional stitch to tighten the entrance of the vagina and to supposedly allow the man more pleasure during penetration; its prevalence is unknown and women are not aware of this practice which is performed without their consent. Then, **in 2015, some 50 doctors, journalists and feminists** published an opinion piece revealing and **denouncing the practice of non-consensual vaginal and anal touching of patients under anaesthesia for a medical procedure**.[10] These revelations provoked indignation and numerous testimonies on social networks, including those used to denounce mistreatment during gynaecological and obstetric care like *#PayeTonUterus, #PayeTonGyneco,*

2 Topçu (2021).

3 Leboyer (1974).

4 Topçu (2021).

5 https://www.cairn.info/revue-spirale-2005-2-page-208.htm

6 Quattrocchi (2019).

7 Azcué and Tain (2021).

8 Bousquet et al. (2018).

9 https://www.isabelle-alonso.com/articles-1/le-point-du-mari-195

10 https://blogs.mediapart.fr/edition/les-invites-de-mediapart/article/060215/le-consentement-point-aveugle-de-la-formation-des-medecins.

#PayeTonAccouchement, #ViolencesObstétricales and *#MonPost-partum*.[11] The progressive liberation of women's voices must have contributed to the visibility of violence.[12]

At the same time, we observe a certain distancing of women[13] from the medicalisation of their childbirth. According to **the National Perinatal Survey** (see below), the choice to use non-medical methods for pain relief doubled from 14.3% in 2010 to 35.5% in 2016.[14] This period also corresponds to the beginning in France of the 'Pill Crisis'[15] which exacerbates the more general questioning of the medicalisation of bodies and the lack of autonomy and control by women over their reproductive bodies.

These **denunciations and the public debates** were taken up by journalists and revived in the following years by the broadcasting of radio programmes[16] and documentaries on the subject,[17] as well as by the publication of comic strips and popular books.[18] Indeed, cultural products on obstetric violence or related issues have emerged. In March 2016, blogger and illustrator Emma published *L'histoire de ma copine Cécile* (The story of my friend Cécile), in which she describes in detail, with drawings, the conditions of her friend's childbirth, including the episiotomy that she had refused.[19] In 2017, the journalist Mélanie Déchalotte published *Le livre noir de la gynécologie* (The black book of gynaecology);[20] one year later, Marie-Hélène Lahaye published her book *Accouchement, les femmes méritent mieux* (Childbirth, women deserve better).[21] Later, documentaries and short films were also produced, such as Ovidie's '*Tu enfanteras dans la douleur*' (You will give birth in pain) in 2019 and Nils Tavernier's '*Et si on s'écoutait*' (Let's listen to each other) in 2021.

All these **mobilisations from 2013 onwards led to the State taking up the issue**. In 2017, an observatory of gynaecological and obstetric violence[22] (IRASF) was created and Marlène Schiappa, then Secretary of State for Equality between Women and Men, commissioned a report from the French High Council for Equality between Women and Men (*Haut Conseil à l'Égalité entre les femmes et les hommes*, HCE) on gynaecological and obstetric violence. The report of 164 pages, giving a lot of space to women's voices (with many quotes from interviews), was published in 2018. Two months later, the French National Academy of Medicine produced a 22-page report on the same issue.[23]

However, despite the fact that it has become a public and political issue (see Figure 12), **there is no consensus on obstetric violence in France and it**

11 Salles (2021).

12 Michel & Squires (2018).

13 This case study uses the term 'women' as an inclusive term, also considering transgender men and other people who self-identify as non-binary who are going to or have given birth.

14 Blondel et al. (2017).

15 Bajos et al. (2014).

16 For instance: 'Maltraitrance gynécologique' [Internet]. France Culture. https://www.franceculture.fr/emissions/sur-les-docks/collection-temoignages-maltraitance-gynecologique.

17 Salles (2021.)

18 Déchalotte (2017); Lahaye (2018).

19 https://emmaclit.com/2016/06/10/lhistoire-de-ma-copine-cecile/.

20 Déchalotte (2017).

21 Lahaye (2018).

22 This report focuses on obstetric violence. But it will also frequently mention gynaecological violence because some documents consider both gynaecological and obstetric violence as inextricably linked.

23 Bousquet et al. (2018) and Academie de Medicine (2019).

continues to generate controversy and debate, particularly within the medical community. Two main elements are at the heart of the controversy: consent and intentionality. The issue of consent came to the fore in 2022 when a member of the government, a former gynaecologist and obstetrician, was accused of rape by civil society for having carried out gynaecological examinations without asking for the explicit consent of patients. These claims rely on the Kouchner law of 4 March 2002,[24] according to which free and informed consent must be obtained for any medical act by the health professional and this consent can be withdrawn at any time. In France, gynaecological consultations are short in duration and consent is therefore often taken for granted as soon as the woman enters the consulting room. The notion of intentionality is also the subject of debates between health professionals and women. The Study Circle of Obstetrician Gynaecologists of Ile de France (*Cercle d'Etudes des Gynécologues Obstétriciens d'Ile de France*, CEGORIF) wrote that 'this term of violence induces a notion of intentionality and it is to us, the health professionals, that it causes violence'.[25] However, the HCE report states that obstetric violence is carried out by women and men who do not necessarily intend to be abusive.

Figure1: List of milestones relating to obstetric violence in France

Date	Events
July 2003	Creation of CIANE
September 2013	Launch of the blog "Marie accouche là" by Marie-Hélène Lahaye
March 2014	Denunciation of "Point du mari" by Agnès Ledig
November 2014	Emergence of #PayYourUterus; #PayYourGyneco on social networks
February 2015	Controversy on vaginal and rectal touching of patients under anaesthesia (Faculty of Medicine Lyon-Sud)
March 2016	Publication of *L'histoire de ma copine Cécile* by the blogger and illustrator Emma
July 2017	Commissioning of a report to the HCE by the Secretary of State for Gender Equality
October 2017	Publication of the *Livre noir de la gynécologie* by Mélanie Déchalotte
End of 2017	Creation of the collective "All Against Obstetrical and Gynecological Violence" (now StopVoG)
January 2018	Publication of *Accouchement, les femmes méritent mieux* by Marie-Hélène Lahaye
June 2018	Publication of the HCE Report on Gynaecological and Obstetric Violence
July 2019	French documentary "Tu enfanteras dans la douleur" by Ovidie
December 2019	First scientific conference on obstetric violence in France (INED, Paris)
February 2020	Launch of Nils Tavernier's short films with the Maison des femmes and the CEGORIF
Spring 2020	Controversy over the wearing of masks during expulsive efforts in the context of the COVID pandemic19
Autumn 2021	Media coverage of the "Darai Affair" on gynaecological violence at Tenon Hospital (Paris)
June 2022	Media coverage of complaints of gynaecological violence against State Secretary Chrysoula Zacharopoulou
June 2022	Prime Minister convenes CCNE to advise on consent for gynaecological examinations

24 Law n°2002-303 of 4 March 2002 on the rights of patients and the quality of the health system.

25 Hatem-Gantzer (2020:179). Translation by the authors of 'ce terme de violence induit une notion d'intentionnalité et nous fait, à nous soignants, violence'.

2.3 Definitions and references

In France, two institutional reports are references in the field of obstetric violence: the HCE report[26] and the report of the French National Academy of Medicine,[27] both published in 2018, following the growing public and media mobilisation on the subject. These two reports address obstetric violence but approach this violence from a different epistemological position.

The HCE report defines gynaecological and obstetric violence as 'the most serious sexist acts that can occur in the context of women's gynaecological and obstetric care. Sexist acts during gynaecological and obstetric care are gestures, words, practices and behaviours carried out or omitted by one or more members of the medical staff on a patient during gynaecological and obstetric care (...). It can take many forms, from the most seemingly innocuous to the most serious'.[28] Based on this definition, the HCE **identifies six types of sexist acts**: (1) Failure to take into account the patient's discomfort, linked to the intimate nature of the consultation; (2) Judgemental comments about sexuality, dress, weight and whether or not she wants to have a child, which refer to sexist injunctions; (3) Sexist insults; (4) Acts (medical intervention, prescription, etc.) carried out without consent or without respecting the patient's choice or voice; (5) Acts or refusal of acts that are not medically justified; and (6) Sexual violence: sexual harassment, sexual assault and rape.[29] It is this definition of the HCE that is mostly taken up by associations like StopVOG.

Entitled '*De la bientraitance en obstétrique. La réalité du fonctionnement des maternités*' (On benevolence in obstetrics. The reality of the functioning of maternity wards), **the report of the French National Academy of Medicine** states that 'the term "obstetric violence" covers any **medical act, posture or intervention that is inappropriate or non-consensual**. It therefore covers not only acts that do not comply with the recommendations for clinical practice but also medically justified acts performed without prior information and/or without the patient's consent or with apparent brutality. Finally, attitudes, behaviours and comments that do not respect women's dignity, decency and intimacy are also cited under this term and are linked to the failure to take pain into account during and after childbirth'.[30]

As can be seen, the **HCE explicitly uses the term 'obstetric violence'** to highlight its structural dimension, while the French National Academy of Medicine focuses on benevolence (*bientraitance*) to highlight its shortcomings. In France, the term 'obstetric violence' is **rarely used by health professionals**, who more

26 Bousquet. et al. (2018).

27 Académie de médecine; (2018).

28 Bousquet et al. (2018: 3). Translation by the authors of 'les actes sexistes les plus graves qui peuvent se produire dans le cadre du suivi gynécologique et obstétrical des femmes. Les actes sexistes durant le suivi gynécologique et obstétrical sont des gestes, propos, pratiques et comportements exercés ou omis par une ou plusieurs membres du personnel soignant sur une patiente au cours du suivi gynécologique et obstétrical (...). Ils peuvent prendre des formes très diverses, des plus anodines en apparence aux plus graves'.

29 Bousquet et al. (2018).

30 Académie de médecine (2018 ::3). Translation by the authors of 'le vocable de 'Violences obstétricales' regroupe tout acte médical, posture, intervention non approprié ou non consenti. Il recouvre donc, non seulement des actes non conformes aux recommandations pour la pratique clinique mais aussi des actes médicalement justifiés réalisés sans information préalable et/ou sans le consentement de la patiente ou avec une apparente brutalité. Enfin, les attitudes, comportements, commentaires ne respectant pas la dignité, la pudeur et l'intimité des femmes sont également cités sous ce terme et rapprochés de la non-prise en compte de la douleur pendant et après l'accouchement'.

often **use the term 'benevolence'** proposed by the Academy of Medicine, or the term **'inappropriate acts'**.[31] On the other hand, the term 'obstetric violence' is used by militant associations[32] and by some academic scholars.[33]

While these two recognised institutes address obstetric violence and make recommendations, it should be noted that there is no legal definition and no specific law as in some Latin American countries. In the absence of a legal framework, the observation and denunciation of such violence does not automatically lead to a trial or even condemnation. For example, in 2021, Professor Emile Darai, an endometriosis specialist practising in one of the main Parisian hospitals, was the subject of several complaints of sexual assault and rape, which allegedly took place during gynaecological consultations. However, although this professor is the subject of a judicial investigation and has been removed from his responsibilities as head of department, he has not been suspended and continues to practise and carry out gynaecological examinations (pending the outcome of the investigation)[34].

Finally, it is important to note that at the institutional level, as here with the French National Academy of Medicine report, **women's voices are often silenced**, while scientific studies emphasise that violence is subjective and therefore depends on the histories and feelings of each individual.[35] It is essential to take into account women's experiences of obstetric care in order to better understand and define obstetric violence. Since 2022, Lucile Faivre-Pierret, a doctoral student at the University of Paris 1 and INED, is working on this reality-based definition by collecting in France the discourse and experiences of women who consider themselves to have experienced obstetric violence.[36]

2.4 Data collection and evidence on obstetric violence in France

2.4.1 Empirical evidence

In France, there is a large body of research in medicine, public health and social sciences on reproductive and sexual health. **But studies on the conditions and experiences of women during gynaecological and obstetric care and during childbirth are scarcer**. The analytical approaches used very rarely focus on violence, but they show that gynaecological consultations can be a place of violence, particularly around contraceptive injunctions.[37] The first social scientific conference on the subject in France only took place in December 2019[38]. This conference was remarkable in its ability to bring together researchers, health professionals and associations. Contributions, using mainly a qualitative approach, were made on obstetric violence in different regions of the world: Europe, Latin America, the Middle East, Asia and sub-Saharan Africa. The participants were

31 Le Ray et al. (2021).

32 Bisch et al. (2020); Evrard (2020); Evrard et al. (2021).

33 Rozée & Schantz (2021); Schantz et al. (2021).

34 In France, medical acts, even without explicit consent, are not condemned because it is difficult to prove sexual abuse or coercion by the health professional.

35 Académie de médecine (2018); Lévesque et al. (2018); Michel & Squires (2018).

36 Ph.D thesis tentatively entitled 'Derrière la notion contestée de 'violences gynéco-obstétricales', objectiver les mauvaises expériences de soin en gynéco-obstétrique. Pour une définition sociologique issue des expériences profanes' (https://www.ined.fr/fr/recherche/chercheurs/Faivre-Pierret+Lucile).

37 Fonquerne (2021).

38 https://www.ined.fr/fr/actualites/rencontres-scientifiques/seminaires-colloques-ined/violences-obstetricales/

numerous, but it should be noted that among the health professionals, midwives were much more numerous than obstetricians. All the papers pointed out that more research is needed on the subject.

In France, **there is no statistical data measuring the extent of obstetric violence**. However, **since 1995**, a **National Perinatal Survey**[39] has been regularly conducted (1995, 1998, 2003, 2010, 2016, 2021) and its results are referenced in the European Perinatal Health report. The latest National Perinatal Survey carried out **in 2021** in all 480 French maternity hospitals (France metropolitan and overseas), including 6 birth centres, involved 13 404 women.[40] For the first time, **women were contacted again two months after giving birth**. For those women who agreed, this follow-up was carried out by telephone or internet. Also for the first time, this latest survey looked at **women's mental health and addressed a few questions on obstetric violence**. It introduced the concept of 'inappropriate care'. This notion can be used as a 'proxy' for the measurement of obstetric violence. But it should be noted that the term 'obstetric violence' is only mentioned once in the report to refer to the current context of the debate on this subject in France and is not adopted by the authors in the rest of the report. The word "consent", which is at the centre of obstetric violence's debate in France, is also absent, although the questionnaire addresses the issue of 'agreement' before a medical act.

The 2021 EPN survey showed that **15.5 % of the women experienced a difficult or very difficult pregnancy** and **11.7 % had a bad or very bad experience of childbirth.**[41] Women's reaction to the discovery of their pregnancy is positive in most cases and no different from the situation of women in 2016. However, their psychological state during pregnancy seems to have deteriorated without it being possible to define with the data from the ENP 2021 and the proportion linked to the pandemic context. The share of women having consulted a health professional for psychological difficulties during pregnancy is increasing (8.9 % in 2021 compared to 6.4 % in 2016).[42] We do not know whether or not this slight increase is related to difficult experiences of obstetrical care.

Concerning the use of technology in childbirth, apart from **induction of labour**, of which the frequency is **increasing** (25.8 % compared with 22 % in 2016), the survey highlights a **decrease in the use of medical interventions** aimed at accelerating labour: fewer artificial ruptures of the membranes (33.2 % among women in spontaneous labour compared with 41.4 % in 2016) and fewer oxytocin administrations (30 % among women in spontaneous labour compared with 44.4 % in 2016), in line with national recommendations. The **caesarean section rate has been stable since the 2000s** in France with a rate of 21.4 % in 2021. Having given birth by caesarean section in a previous childbirth remains the main risk factor for a caesarean section. The rate of **instrumental vaginal childbirth remains stable** at around 12 %. Midwives perform 88.6 % of deliveries by spontaneous vaginal childbirth, a rate that is stable compared to 2016 (87.5 %). The **episiotomy rate**, which had already been **declining** for several decades, has fallen sharply from 20.1 % in 2016 to 8.3 % in 2021, in line with national recommendations.[43]

39 Enquête Périnatale Nationale, EPN.

40 Le Ray et al. (2021). In 2021, France recorded over 740 000 births.

41 Le Ray et al. (2021).

42 Le Ray et al. (2021).

43 Le Ray et al. (2021).

2.4.2 Relevant manifestations of obstetric violence

The 2021 EPN survey conducted two months after childbirth showed that about 10 % of women reported having been exposed sometimes or often during their pregnancy, childbirth or stay in the maternity facility to inappropriate words or attitudes from health professionals and about 7 % to inappropriate gestures. These occur in all contexts (consultation, ultrasound, emergency, delivery room, epidural), but are more frequent during the stay in the maternity department.[44]

Based on the testimonies of women and couples, Anne Evrard, vice-president of CIANE (*Collectif InterAssociatif autour de la NaissancE*), reported a similar situation: infantilising, sexist, humiliating, denigrating and even threatening and intimidating comments. Here are some of the specific feelings she collected from women who claim to have experienced obstetric violence: the disruption of contact and dialogue with the health professionals; the loss of the woman's place as interlocutor and a key actor; a loss of confidence in the team and great loneliness; a feeling of devaluation, humiliation and infantilisation; the failure to take account of specific feelings, the denial of her ability to make legitimate choices considered essential; a feeling of dispossession of her role, her body, her baby or, conversely, of being reduced to a mere body; an experience of isolation and abandonment and, in an emergency, the absence of a person dedicated to explaining or even simply contacting her; and the emergence of fear and the risk of death without it being possible to express it openly.[45]

In the 2021 EPN, women also reported that **health professionals did not always ask for their consent before performing a medical procedure** (e.g. vaginal touching during pregnancy) or intervention (e.g. administering oxytocin, performing an episiotomy or emergency caesarean section during childbirth). Indeed, for 4.2 % of the women, the health professional(s) never asked for consent before performing a vaginal touch during pregnancy; for 11 % of the women, consent was sometimes requested; and for 78 %, consent was systematically requested. During labour and childbirth, in almost 20 % of cases women report that their agreement was not sought for the administration of oxytocin during labour, in 51.8 % of cases for the performance of an episiotomy and in 34.5 % of cases for the performance of an emergency caesarean section (for women exposed to these interventions).[46]

According to associations, the media and scientific literature, all women are likely to experience violence during pregnancy and childbirth.[47] Nevertheless, some empirical and scientific data lead to the hypothesis that women who are already discriminated in their daily lives because of their colour, disability, living conditions, legal status, addiction, etc.,[48] may be in France more exposed to obstetric violence than others. The *Trajectoires & Origines survey*, conducted by the French National Institute for Demographic Studies (INED) and the National Institute of Statistics and Economic Studies (INSEE) in France in 2008–2009 showed **significant inequality and discrimination in healthcare in France and identified the main factors as structuring discrimination in the field of health: being a woman, being an immigrant from Africa and the French overseas, and**

44 Le Ray et al (2021).

45 Evrard (2020).

46 Le Ray et al. 2021).

47 Schantz et al. (2021).

48 Lévesque et al. (2018:232).

being Muslim.[49]

Similarly, the work of Priscille Sauvegrain has shown the social inequalities of access and care in maternal health: differentiated access to birth preparation according to women's socio-demographic characteristics,[50] a higher risk of maternal mortality among immigrant women in France, especially those born in sub-Saharan Africa[51] and a different care and treatment of black women during childbirth.[52] She has also reported a higher caesarean section rate among women from sub-Saharan Africa. The healthcare teams justify this practice for several reasons: the poorer health of African women and the anatomical characteristics of their pelvis, which is smaller and anthropoid in shape.[53] **All the studies have therefore shown that some women receive lower-quality obstetric care in France** than other women. Among the various reasons, it is important to remember that the **prejudice of the Mediterranean syndrome** persists in Europe, including in France. The 'Mediterranean syndrome' designates 'a **form of exaggeration of the pain of patients from Mediterranean cultures** and especially from North Africa, who are judged to be more anxious, complaining and soft and for whom it would therefore be a matter of following up their complaints less'.[54] On this matter, the French press published an article in September 2022 entitled 'Childbirth: the "Mediterranean syndrome" invites itself to the delivery room'.[55]

Racialised women may also be perceived and discriminated in relation to other social differentiation factors, in particular their social background, level of education, income, living place or deviation from the 'healthy weight' norm. Their deviation from the 'reproductive norm' that in France socially defines when and with whom to have children[56] could be another factor that increases exposure to obstetric violence: women considered too young or too old to have children, those considered to have 'too many' children, same-sex couples, transgender men, people who are not in relationships, etc.

The **Academy of Medicine** considers that socially and **psychologically 'fragile' women** are **more likely to experience obstetric violence**. It states: 'It is important to pay particular attention to the screening of particularly fragile patients (psychiatric history, patients who have been victims of sexual or conjugal violence) in order to allow for appropriate care, which is the only way to limit the risk of psychological trauma during childbirth'.[57]

According to the HCE report, **all the violence described here is carried out by both men and women,** whatever their speciality, i.e. gynaecologists, obstetricians, midwives, anaesthetists, nurses and any other health professionals who

49 Rivenbark & Ichou (2020).

50 Sauvegrain (2008).

51 Sauvegrain et al. (2017).

52 Sauvegrain (2012).

53 Sauvegrain (2013).

54 Loriol et al. (2010), cited in Lambert et al. (2022).

55 https://www.mediapart.fr/journal/france/120922/accouchement-le-syndrome-mediterraneen-s-invite-en-salle-de-naissance

56 Bajos & Ferrand (2006).

57 Académie de médecine (2018:14). Translation by the authors of 'Il est important d'accorder une attention toute particulière au dépistage des patientes particulièrement fragiles (antécédents psychiatriques, patientes victimes de violences sexuelles ou conjugales) afin de permettre une prise en charge adaptée qui, seule, permettra de limiter le risque de traumatisme psychologique lors de l'accouchement.'

work in the field of obstetrics and gynaecology.[58]

2.5 Root causes of obstetric violence

The use of the **concept of 'obstetric violence' by the HCE report is significant**. Using this concept allows the structural dimension of this violence to be made visible[59] and to be included in the continuum of gender-based violence.[60] Moreover, **the report explicitly makes the link between sexism and violence during gynaecological and obstetric care** in the title. It states that 'sexist acts during gynaecological and obstetric care (...) are part of the history of gynaecological and obstetric medicine, which is marked by the desire to control women's bodies (sexuality and capacity to give birth)'.[61]

According to Marie-Hélène Lahaye, the Belgian lawyer who was the first in France to highlight the concept of obstetric violence through her blog '*Marie accouche-là*', obstetric violence is the sum of two types of violence: institutional violence and gender violence.[62] Obstetric violence in France is part of the history of gynaecology, which produces, reproduces and even accentuates gender norms; and of the organisation of the healthcare system, which leaves little room for both humane and effective medical care.

Whereas at the beginning of the last century almost all births took place at home, **today 99 % of births take place in hospitals in France**,[63] while in 2020 only 92 births took place in the six birth centres in metropolitan France. But a process of institutionalising birth was put in place at the end of the World War II in order to better supervise and make childbirth safer. This 'major move'[64] has led to profound changes in maternity care, perinatal healthcare and childbirth techniques. **In France, the closure of small maternity hospitals, hospital mergers and partnerships and public–private cooperation have led to the closure of more than half of all maternity hospitals since 1975** (a reduction in the total number of maternity units from 1 369 in 1975 to 483 in 2021). Moreover, the childbirth in France is characterised by the homogenisation of the care offered and a concentration of the births in hospitals. While home birth is almost impossible[65] and even considered 'a deviant practice',[66] giving birth in a birth centre (*maison de naissance*) remains a laborious and difficult undertaking. This leaves individuals and couples with little freedom to choose where to give birth.

Moreover, French obstetrics is one of the most medicalised in Europe.[67] As in the rest of the world, the medicalisation of maternal health in France has led to a significant reduction in complications during pregnancy and childbirth and in maternal and infant mortality. However, with the gradual introduction of standardised places and practices mobilising technical, surgical and medicinal

58 Bousquet et al. (2018: 3)

59 Sadler et al. (2016).

60 Delage et al. (2019).

61 Bousquet et al. (2018:3). Translation by the authors of 'Les actes sexistes durant le suivi gynécologique et obstétrical (...) s'inscrivent dans l'histoire de la médecine gynécologique et obstétricale, traversée par la volonté de contrôler le corps des femmes (sexualité et capacité à enfanter)'.

62 Lahaye (2018).

63 National Perinatal Survey (2016).

64 Thébaud (2010).

65 Pruvost (2016).

66 Cardi et al. (2016).

67 Pruvost (2018).

objects, this medicalisation has been accompanied by a hypertechnicalisation of birth, leaving women with little decision-making power and autonomy during childbirth.[68] Today in France, childbirth is governed by the notions of risk and surveillance and by the increased use of technosciences.[69] In 2021, three practices characterise obstetrics in France: a high use of epidural analgesia (82.7 % of deliveries), a high use of oxytocin (a hormone used to increase the frequency and/or intensity of uterine contractions – 30 % of women in spontaneous labour were given this hormone) and a quasi-systematic use of the gynaecological position (93.9 %). Nevertheless, caesarean section rates have been stable since the early 2000s (around 20 %) and episiotomy rates are gradually decreasing as already mentioned.[70]

Some health professionals, particularly midwives, question their working conditions (lack of staff in hospitals, budgetary restrictions) and deplore the application of a series of medico-technical and protocol-based gestures[71] which no longer allow them to adopt a caring, listening and supportive attitude.[72] **Gynaecological and obstetric violence is part of this new context of pressure on the French healthcare system. Poor working conditions, lack of quality services and facilities, lack of adequate training,** the profit motive applied to health facilities, and the constraints imposed on health professionals are factors that favour the occurrence of gynaecological and obstetric violence.[73] These conditions and constraints are no longer compatible with humane medical care and the explicit collection of informed consent.

Anne Evrard, vice-president of CIANE, based on the testimonies of women and health professionals, argues that most often it is the absence of satisfactory communication between health professionals and women that signals the onset of obstetric violence.[74] Yet the impact of the behaviour and attitudes of health professionals on the immediate and longer-term experiences of women or couples is crucial.

68 Bousquet et al. (2018).

69 Carricaburu (2007); Clarke et al. (2003).

70 Le Ray et al. (2021).

71 Morel (2007-2008).

72 Coulm (2013).

73 Lévesque et al. (2018).

74 Evrard (2020).

2.6 Consequences of obstetric violence

In France, as elsewhere, violence has consequences for women's mental health, but also for their physical and social health. The physical and psychological damage is serious and long-lasting, putting the woman's overall health at risk.

The main consequences of obstetric violence include depressive symptoms and post-traumatic stress disorder. The report of the Academy of Medicine acknowledges that 'all these defects in the quality of care, whether real or felt by the patients, can lead to major psychological disturbances similar to post-traumatic stress disorder (PTSD), which will require complex psychosomatic treatment. This PTSD, which affects nearly 5 % of patients, may be secondary to a life-threatening emergency situation, which is rightly distressing, but is most often the consequence of daily obstetric practices, which are technically irreproachable, but humanly deficient'.[75] The 2021 EPN survey showed that 16.7 % of women had major depressive symptoms at two months post-partum.[76]

Evrard lists all the interrelated consequences that CIANE has observed as a result of obstetric violence.[77] On a psychological level, she notes loss of sleep, loss of appetite, nightmares, bad memories, repetitive flashes of the most difficult moments, major anxiety and frequent crying. She observes that obstetric violence even affects women's self-esteem, leading to a degraded self-image, guilt and anger. On a physical level, obstetric violence can lead to diffuse body pain and persistent perineal pain, even in the absence of injury or episiotomy. On a social level, isolation from family and friends for fear of being misunderstood and an inward-looking attitude were observed, as well as an inability to return to work because of obsession with the events, sadness, discouragement and intense physical and psychological fatigue. Difficulties in the relationship with the child were also observed, as well as a severely impaired or non-existent sexuality, and even marital crises. This violence can also lead to a loss of confidence in health professionals, to the non-use or under-use of health services and even to seeking medical services elsewhere for fear of being confronted with this violence again.

Finally, while it is not possible to establish a direct link with obstetric violence experienced by women, it is important to point out that in France, suicide is currently the leading cause of maternal mortality (along with cardiovascular disease).[78]

75 Académie de médecine (2018:13). Translation by the authors of 'Tous ces défauts dans la qualité de la prise en charge, bien réels ou ressentis par les patientes peuvent entrainer des perturbations psychologiques majeures analogues à un état de stress post-traumatique (SPT) qui nécessitera une prise en charge psychosomatique complexe. Ce SPT, qui toucherait près de 5 % des patientes, peut-être secondaire à une situation d'urgence vitale, angoissante à juste titre, mais s'avère le plus souvent la conséquence de pratiques obstétricales au quotidien, techniquement irréprochables, mais humainement défaillantes'.

76 Le Ray et al. (2021).

77 Evrard (2020).

78 Inserm and Santé Publique France (2021).

2.7 Obstetric violence and Covid-19

In France, as everywhere, **the Covid-19 pandemic forced the reorganisation of care**, including in maternity facilities, sometimes in a hurry and without clear institutional instructions. It also **increased the difficulties of access to care** (due to the successive lockdowns) and also the stress and uncertainty of health professionals and women.

In France, two practices drew the attention of associations and health users from the start of the pandemic, were relayed on social networks and led to the re-emergence in the spring of 2020 of debates on obstetric violence: **the imposition in some facilities of the wearing of masks during labour**; and the **refusal, in some maternities, to allow patients to be accompanied during childbirth**. On this point, beyond the right of women to be accompanied by a person of their choice during childbirth, studies show the positive health impacts of this accompaniment: it increases the probability of a spontaneous childbirth (without caesarean section) and reduces the time of childbirth, the use of instruments and analgesia and negative perceptions of childbirth (and therefore post-partum depression).[79] These conditions gave rise, among other things, to a blog post by Marie-Hélène Lahaye, entitled '**When you're at war, you don't give birth at the front'** (*Quand on est en guerre, on n'accouche pas sur le front*), posted on 29 March 2020.[80]

Faced with these new constraints around hospital childbirth, a sizeable share of women (25.8 %) in France said they were considering giving birth at home during the pandemic without prior preparation. This was reported in the results of the survey of **the collective StopVOG, a French collective created in 2017 to denounce obstetric violence**.[81] StopVOG conducted an online survey in May 2020 to report on women's experiences, the protocols put in place and respect for women's rights and human rights during this period of crisis. This survey collected 2 727 responses from women who gave birth between 15 February and 31 May 2020. It reported that 25 % of respondents had an induced childbirth (compared to 22 % in the 2016 EPN survey); that 46 % had to wear a mask during childbirth and, of the 8.4 % who had an episiotomy, 71.4 % stated that their consent was not sought. It also reports that 75 % of respondents showed at least three signs of depression and PTSD. This report was accompanied by several extracts of testimonies as well as a mapping of France of these testimonies. **This report warned, from the very first months of the pandemic, that the health crisis context has aggravated obstetric violence**.

At the same time, a **scientific European survey** (IMAgiNE EURO – Improving MAternal NEwborn care in the EUROpean region), coordinated by the **SS WHO Collaborating Centre IRCCS Burlo Trieste**, was carried out on the conditions of childbirth in different European countries, from the point of view of women who have given birth and of health professionals working in perinatal and obstetric care services.[82] Regarding the scores of quality of maternal and new-born care (QMNC) defined by the World Health Organization, France has higher scores than its European neighbours during the Covid-19 pandemic. However, **women who gave birth in France reported difficult conditions of childbirth**.

79 Bohren et al. (2017).

80 https://blogs.mediapart.fr/marie-helene-lahaye/blog/290320/quand-est-en-guerre-n-accouche-pas-sur-le-front.

81 Bisch et al. (2020).

82 https://www.burlo.trieste.it/ricerca/imagine-euro-improving-maternal-newborn-care-euro-region.

Among respondents who underwent labour (497 individuals), 11.5 % declared having had fundal pressure[83] (for instrumental vaginal birth, IVB), 32.4 % received no pain relief after a caesarean session, 47.7 % of respondents declared that they had no choice of birth position, 62.5 % that no consent has been requested (for IVB), 34.6 % that they were not involved in choices, 50.9 % that their companionship was not allowed, 23.1 % reported not having been treated with dignity and 18.5 % declared abuse (physical, verbal and emotional).[84] Although these two voluntary surveys have obvious biases (more women with a particular experience may have responded), they provide interesting and quite alarming indicators of the conditions of childbirth during the crisis in France.

The qualitative research, Mater-Covid19[85], conducted in 2021 and 2022, complements these quantitative surveys. Funded by the French National Research Agency, it aims to document the experiences of women who gave birth during the pandemic in the Paris region and on Reunion Island. The question of obstetric violence was at the centre of this research, questioning whether the health crisis context had exacerbated this violence. The 55 interviews conducted with women who had given birth during three key periods of the pandemic showed women at the end of their pregnancy had a strong apprehension of giving birth 'alone'. The large discrepancy between what the women feared and the actual conditions of their childbirth meant that they declared that 'everything went well', or even that they were 'lucky'. **Nevertheless, few of them had anticipated the difficulties of being alone with a newborn in the post-partum period**. Thus, the pandemic created a great deal of loneliness among the women, accentuated by a feeling of 'stolen motherhood'. The majority of women overall did not describe a positive experience of childbirth, although they did not link this to the notion of obstetric violence. The degree of intensity of this experience is related to women's perceptions of motherhood and medicine, as well as to their personal and family history.[86]

This research also included 34 interviews with health professionals who accompanied women in childbirth during the pandemic. These experiences were marked by a polarisation of feelings, with some experiencing great 'excitement' while others' daily lives were strongly marked by fear. The health crisis undermined the mental wellbeing of many of them; it may have been indicative of a more general malaise and the re-emergence of controversies about obstetric violence reinforced their malaise.[87]

83 This practice has been discouraged by the French National Authority for Health (*Haute Autorité de la Santé*, HAS) since 2007 because it is considered traumatic for women and can lead to complications.

84 Lazzerini et al. (2021).

85 https://www.mater-covid19.org/

86 Rozée and Schantz (2023).

87 Schantz & Ferrere (2022).

2.8 Achievements and challenges in collecting and monitoring data

As this report points out, obstetric violence has a systemic dimension,[88] i.e. here linked to the current weaknesses of the French health care system but also to gender, social class and racial inequalities, which are prevalent in French society.[89] It also has a subjective dimension,[90] i.e. it is linked to the personal, social and medical history of each individual. This subjective dimension means that the same act or behaviour will have different consequences for different people. **These systemic and subjective dimensions make it difficult to identify and therefore report violence.** Moreover, many women who, for instance, have been badly spoken to, who have been subjected to an unjustified medical procedure or whose pain has not been taken into account and relieved, will not systematically identify these acts and behaviour as violence. The same patterns can be observed for all gender-based violence.

All this makes it difficult to understand obstetric violence and in particular to measure its prevalence, from the perspective of women in France. Conducting such research from women's perspective and experience is an urgent and necessary challenge, including with socially vulnerable and marginalised women.[91] The StopVOG collective also advocates that systematic studies be conducted. In particular, it proposes adding specific questions to the National Perinatal Survey on obstetric violence, on women's satisfaction during their medical care, and on their free and informed consent. It also proposed that these questions be asked at the end of the maternity ward (as is the case today) and then again one year later (in the new version, women are consulted two months later, as mentioned above). For the StopVOG collective, 'it does not seem possible to experience and analyse events at the same time. Sometimes it is necessary to step back to understand what really happened and to grasp all the dimensions and impacts.'[92]

Similarly, the French National College of Midwives[93] published in 2023 a commentary which proposes a set of standardised questions adapted to the French context, with the women's point of view as a starting point. The CNSF proposes that this set of questions could be used in surveys like the next National Perinatal Survey, to find out the percentage of women who report having been exposed to obstetric violence.[94]

Another important challenge is ensuring and raising awareness and commitment of health professionals, who need to take a more critical view of their practices to ensure quality care.[95] Their training is thus at the heart of this challenge as the HCE report mentions that the prevention of obstetric violence requires the training of health professionals.[96] This is also what emerges from Master's research on gynaecological and obstetric follow-ups carried out with 22 women interviewed, for whom obstetric violence is the result of a lack of awareness and

88 Sadler et al. (2016).

89 Lévesque and Ferron-Parayre (2021); Lévesque et al. (2018).

90 Lévesque & Ferron-Parayre (2021); Michel & Squires (2018).

91 Lévesque et al. (2018).

92 (Bisch et al. 2020: :51). Translation by the authors of 'il ne paraît pas possible de vivre les événements et de les analyser en même temps. Un recul est parfois nécessaire pour comprendre ce qui est réellement arrivé et en saisir toutes les dimensions et impacts' p.51.

93 Collège National des Sages-Femmes, CNSF

94 Sauvegrain et al. (2023).

95 Lévesque & Ferron-Parayre (2021).

96 Bousquet et al. (2018).

therefore of training of health professionals.[97]

2.9 Relevant initiatives and their impact

2.9.1 Initiatives leading to political action

Relevance of the topic in political and institutional debate

As described at the beginning of this case study, the scale of civil society mobilisation from the mid-2010s in France led to the creation of a specific Observatory and the publication of a government report presenting recommendations to combat obstetric and gynaecological violence.

More recently, in 2021 and 2022, two significant public and publicised cases led to the consideration of obstetric violence issues within the government. The first one concerns the Professor Emile Daraï (see above), who was the subject of 190 testimonies of violence and 28 complaints of rape, including on minors (#NousToutes 2022). The second concerns a member of the government. In June 2022, an investigation was opened against Chrysoula Zacharopoulou, Secretary of State and former gynaecologist, accused of rape and sexual assault by two patients and violence by another. Faced with the growing number of charges and complaints, Prime Minister Elisabeth Borne decided to refer the matter to the National Consultative Ethics Committee (CCNE) on 6 July 2022.[98] The committee then organised hearings with health professionals, collectives and associations such as StopVOG and CIANE and other experts. It was expected to give its opinion on the notion of consent during gynaecological examinations and make recommendations by the end of 2022. These recommendations will provide a framework for collecting consent and clarifying expectations of health professionals during gynaecological examinations. [99]

Degree of recognition of the topic by healthcare providers

Within the healthcare community, the positions regarding public denunciations of obstetric violence are not homogeneous. **In other words, there is no consensus on obstetric violence in the medical community, and the debate over the use of terms to qualify it (violence vs lack of benevolence or abuse) is revealing.**

These debates were observed during the hearings held prior to the drafting of the HCE report in 2017 and then regarding its content. Various midwifery professional organisations responded to requests for hearings. Then, the CNSF issued a reserved opinion on the HCE report, but welcomed its publication for the important questions it raised in public debate. Conversely, the French National College of Obstetricians and Gynaecologists (*Collège National des Gynécologues Obstétriciens Français*, CNGOF) did not wish to participate in the working groups and criticised the report when it came out. The organisation refuted the conclusions,

97 Désétables (2022).

98 https://www.elle.fr/Societe/News/Violences-gynecologiques-Elisabeth-Borne-saisit-le-Conseil-national-d-ethique-sur-le-consentement-4034668.

99 At the time of writing, the CCNE report was not published yet

saying they did not take sufficient account of the very hard working conditions of health professionals in the field of perinatal care. This led the then-president of the CNGOF to declare that obstetricians-gynaecologists were the victims in this debate. Some health professionals denounced this 'gyneco bashing'.[100]

However, in October 2021 (in the midst of the highly publicised 'Darai' affair described above), the CNGOF published on its official website that 'Professionals are perfectly aware of the particularity of the gynaecology or obstetrics consultation, which touches on the psychic and physical intimacy of women. This consultation requires a listening, an attitude, a dialogue and a physical examination in a spirit of benevolence and mutual respect.'[101] They suggest that practitioners in France adhere to 'the gynaecology and obstetrics consultation charter' and display it in their waiting rooms, so that each woman can read it before the consultation. This charter recalls the objectives and purposes of gynaecological examinations, as well as the rights of patients (their privacy and intimacy must be respected, their consent must be obtained and it can be withdrawn at any time). Once again, the CNGOF uses the term benevolence in this official statement.

The lack of acceptance of the term 'violence' is mainly based on the lack of consideration of the working conditions of professionals. But it mainly comes as well from the fact that many professionals consider that the idea of intentionality underlies the concept (which the HCE report refutes). In this regard, the report of the French Academy of Medicine considers that the sometimes virulent criticisms of practices and attitudes described as 'obstetrical violence' have tainted healthcare relationships, in particular the mutual trust between patients and health professionals, which is essential for serene and quality medical care. Moreover, according to this report, these criticisms do not take into account the real advances in birth safety, of which health professionals can be proud, and which do not deserve a global, outrageous and unfair questioning of these same professionals.[102]

Despite these disagreements, as described above, the CNSF has just published a commentary which emphasises the importance of recognising and measuring the extent of obstetric violence and the need to look at it from the women's perspective.[103] Similarly, in 2022, the French Society of Perinatal Medicine (*Société Française de Médecine Périnatale*) is setting up a working group on benevolence in perinatal health; this group is supposed to start working in 2023.

Degree of recognition of the topic by the general public and women

In France, there have been no media campaigns on obstetric violence and it is therefore difficult to measure the degree of awareness and acceptance of women and the public on this issue.

100 Sauvegrain et al. (2023)

101 Translation by the authors of 'Les professionnels ont parfaitement conscience de la particularité de la consultation de gynécologie ou d'obstétrique qui touche à l'intimité psychique et physique des femmes. Cette consultation nécessite une écoute, une attitude, un dialogue et un examen physique dans un esprit de bienveillance et de respect mutuel'.

102 Académie de médecine (2018:18).

103 Sauvegrain et al. (2023).

2.9.2 Initiatives to combat obstetric violence

Relevant initiatives to address the topic to general public

The Collective Stop VOG is very present in the media, on social networks and strongly participates in the public dissemination of information on obstetric violence in France, including during the Covid-19 crisis, when they ran an awareness campaign on changes in childbirth protocols during the pandemic. The collective was created at the end of 2017, 'to end the taboo of obstetric violence'. In 2022, Sonia Bisch, the founder of and spokeswoman for the collective, declared that the collective received more than 200 testimonies per month, of which excerpts are made visible through *#StopOmerta*[104]. Sonia Bisch's media career is representative of the progressive awareness of civil society. She gave birth to her first child in 2015, a childbirth that she experienced very badly. She testified for the first time in August 2017, in a report by the news channel BFM TV accompanying the announcement of the commissioning of the HCE report on obstetric and gynaecological violence.[105] She is filmed at home, blurred, from behind and in silhouette, under a changed first name. But she then testified with her face uncovered on the occasion of the first demonstration in France against gynaecological and obstetric violence, on 25 November 2017.

Sonia Bisch also provided testimonial in the first French-language feature documentary on obstetric violence, *Tu enfanteras dans la douleur*, directed by Ovidie.[106] This documentary, broadcast on a national public channel (Arte, broadcast on 16 July 2019), also marked a turning point in the visibility and denunciation of obstetric violence.[107] For the first time, the testimonies were made openly, showing that the shame should be shifted from victims to perpetrators and that the taboos on the subject must be lifted. While the open testimonials were important, just as important was the content: the women recounted their childbirth with sometimes very strong terms such as 'massacres'; they also explained the consequences, the trauma left by the experience, and that it was far from being 'the best day of their lives'. The documentary even carried testimony of the then Secretary of State for Equality between Women and Men, Marlène Schiappa, who narrated how she experienced obstetric violence during her last childbirth.

The French local and national media continue to publish information and mobilise around obstetric violence. A recent article on the issue appeared in *Le Monde*, one of France's leading daily newspapers, entitled 'Can you advise me how to find a non-violent gynaecologist: faced with the fears of some patients, the embarrassment of practitioners'.[108] The article demonstrated the new importance of the subject in the public space, while also describing the gap between women and some health professionals.

104 See the testimonies collected on @StopVOG twitter account: https://twitter.com/StopVOGfr?ref_src=twsrc%5Egoogle%7Ctwcamp%5Eserp%7Ctwgr%5Eauthor

105 BFM TV. Violences obstétricales : 'J'ai eu des douleurs immenses', témoigne une mère. BFM TV [Internet]. 3 August 2017.See: https://www.bfmtv.com/sante/violences-obstetricales-j-ai-eu-des-douleurs-immenses-temoigne-une-mere_VN-201708030099.html.

106 Ovidie (2019).

107 Salles (2021).

108 https://www.lemonde.fr/societe/article/2022/10/12/paroles-de-gynecologues-obstetriciens-sur-leurs-pratiques-si-la-defiance-s-installe-avec-les-patientes-ce-sera-du-perdant-perdant_6145397_3224.html.

Relevant initiatives to involve and train health professionals in recognising, understanding and preventing obstetric violence

There are few initiatives to train health professionals in France. These include the original production in 2020 of three short training films entitled '*Et si on s'écoutait?*' (Why don't we listen to each other?) by the French actor and director Nils Tavernier, in collaboration with CIANE, the *Maison des Femmes* (a care centre, attached to the Delafontaine hospital, for women in difficulty or victims of violence)[109] and the CEGORIF[110]. Based on testimonies collected by CIANE, they portray 'ordinary' obstetric violence. Three situations are described: a consultation in a private gynaecological practice to obtain information on abortion, a childbirth and a consultation in an obstetric emergency room for a miscarriage. The films show the distress of women faced with a lack of time and attention from health professionals and the inappropriate and infantilising words used by some professionals. However, the violence committed does not seem to be intentional. This is seen through the portrayal of the difficult working conditions of the health professionals: exhausting hours, few holidays, many patients to take care of and lack of staff.[111] These short films, available online, were made to be screened and discussed in training courses for health professionals intending to work in perinatal and obstetric care, within the departments or in discussion groups with patients. The *Maison des Femmes* states that the aim of this mini-series was to open up dialogue between patients and health professionals to enable a better understanding of the expectations of some and the difficulties of others, with a view to improving overall care practices.
With the same objective, CIANE and social science researchers are increasingly present in midwifery schools and medical courses to raise awareness and train health professionals on the issue of obstetric violence. An inter-university diploma entitled 'Taking charge of violence against women towards good treatment' (*Prise en charge des violences faites aux femmes vers la bientraitance*)[112] includes a module entirely dedicated to ethical reflection on care and more particularly on consent to care and violence in care. This diploma is coordinated by an obstetrician gynaecologist, Dr Perrine Millet.

Relevant initiatives to support women in the exercise of their reproductive rights

Created in 2003, CIANE (Collectif InterAssociatif autour de la NaissancE) is the leading patient association in the field of perinatal health. It is a group of some 30 parents' associations. Some are generalist, others deal more specifically with caesarean sections, breastfeeding, home birth, pre-eclampsia or hyperemesis gravidarum. CIANE members participate in working groups within HAS and the CNGOF, communicate at conferences and also publish scientific articles on obstetric violence.[113] **It has now become one of the main active associations that supports women and families who have experienced obstetric violence**, by helping them to denounce these practices, to get answers to their questions about the poor medical treatment they may have suffered, and by accompanying them during hearings with health professionals and even

109 https://www.lamaisondesfemmes.fr/.

110 https://www.terrafemina.com/article/violences-obstetricales-ces-trois-courts-metrages-de-nils-tavernier-denoncent_a352606/1.

111 Salles (2021).

112 https://formations.univ-grenoble-alpes.fr/fr/catalogue-2021/du-diplome-d-universite-DU/diplome-inter-universitaire-prise-en-charge-des-violences-faites-aux-femmes-vers-la-bientraitance-ITZR6S0W.html

113 Evrard (2020); Evrard et al. (2021).

during legal proceedings.

CIANE is at the forefront of the initiative to set up birth centres in France. Following demands to find alternatives to highly technical and medicalised hospital birth delivery, the French government set up birth centres in 2016 (Law 2013-1118 of 6 December 2013), the aim of which is to offer alternative reception facilities for women with a physiological birth as well as overall support at birth. There are eight birth centres in France: six in continental France and two in the French overseas territories (Guadeloupe and Reunion Island). In October 2020, the French Social Security Financing Bill extended the piloting of these 8 birth centres and authorised the opening of 12 additional birth centres in 2022. Birth centres provide a space where women who wish to do so, whose pregnancy is not considered to be at risk, can regain control, autonomy and decision-making power over their body and their birth and give birth as 'naturally' as possible (i.e. without medication or instruments). But despite the creation and development of these centres, they remain insufficient to meet the growing demand. In 2018, only 506 women (0.07 %) in 2018 gave birth in one of the then eight birth centres in France.[114]

In contrast to other European countries, the possibility of experiencing childbirth outside hospitals remains very limited[115] and is still perceived as dangerous and irresponsible. It is almost impossible to find insurance for midwives wishing to perform home births, making this mode of practice extremely difficult. Several midwives have recently been banned from the Council of the Order of Midwives (*Conseil de l'Ordre des Sages-Femmes*) as a result of this poorly regulated practice in France.[116] **While** according to a February 2020 opinion poll, **the public fully supports birth alternatives such as birthing centres**,[117] there is no consensus among health professionals.[118] Some professionals argue that it is preferable, safer and easier to label hospital maternity units that respect and promote women's autonomy and choice during childbirth (where 'label' in English is more equivalent to the idea of 'accreditation' or 'approval'). In 2019, the CNGOF proposed labelling maternity hospitals that respect the good treatment and transparency of their practice during childbirth, and the label *Maternys* was therefore created.[119] On a voluntary basis, maternity facilities that apply for this label are committed to the benevolence and transparency of their service by following the 12 recommendations made by the CNGOF. On the first webpage of initiative, Professor Joelle Belaisch-Allart, President of the Label Committee, states 'Labelling maternity units that place benevolence at the centre of their concerns is more necessary than ever. The objective is to entrust part of the quality control to the women themselves; taking into account the words of women to improve our practices is our collective ambition'.[120] However, the effects of such a label on women's actual experiences are still unknown.

114 Chantry et al. (2019).

115 In France, less than 1% of births take place outside a health facility in 2016 (Insee, civil status statistics, 2016).

116 Sestito (2017).

117 https://www.ipsos.com/fr-fr/les-maisons-de-naissance-plebiscitees-par-9-francaises-sur-10.

118 See the communication of the CNGOF 'Generalization of the Birth Centres or more means for the maternities? The CNGOF's response to the Senate', published on 9 March 2020.

119 https://www.maternys.com/label-cngof-maternys/.

120 Translation by the authors of 'labelliser les maternités qui mettent la bientraitance au centre de leurs préoccupations s'avère plus que jamais nécessaire. L'objectif est de confier désormais une partie du contrôle qualité aux femmes elles-mêmes ; tenir compte de la parole des femmes pour améliorer nos pratiques, telle est notre ambition collective'.

As part of the 2005–2007 French perinatal plan, the concept of the 'birth plan' was established. Produced in the first trimester of pregnancy, the birth plan is **a document to be filled in by the future parents, to declare their wishes concerning the childbirth** (for instance, whether or not they accept a medication or refuse a medical procedure). However, the few studies that collect this information and the informal discussions between people who have given birth show that this plan is not always followed. Although the proportion of women who have drawn up a birth plan has tripled between 2016 and 2021, they are still few in number to take this step, 10.2 % in 2021. Of the women who expressed written or oral requests, 92.5 % were able to express them to the team; the most frequent requests were to be able to have skin-to-skin contact with their baby (67.3 % of women expressing requests), to be able to walk or change position (60.1 %) or to limit medical procedures (52.2 %). The proportion of women declaring that they had 'no particular requests' for childbirth was high (70.1 %), although it is not clear whether this result reflects confidence in the healthcare team or, on the contrary, the fact that women do not dare to express requests, or even that they are unaware of this possibility.[121] In the same vein, **the early postnatal interview (EPNP) has become a mandatory step in the care of post-partum women in France since July 2022** (Article L2122-1 of the Public Health Code). The introduction of this interview follows numerous requests from perinatal professionals and user representatives to deal with depression, suicide and post-traumatic syndromes. It is part of the 'First 1000 Days' programme launched by UNICEF and taken up by the French government. Although it is not directly related to obstetric violence, it is a sign of the awareness of the need to consider women's mental health after childbirth.

Relevant initiatives to deconstruct general assumptions on childbirth, (over) medicalisation of reproductive health, gender and other stereotypes, naturalised behaviours, beliefs, practices, power dynamics, etc.

Deconstructing the obstetric paradigm based on the notion of risk is difficult in France, particularly because of the health professionals whose medical training is based on the belief that childbirth is a risky event, that must be medically and technically supervised by a competent and equipped medical team. Some social science studies contribute to deconstructing childbirth as a risky medical event. Similarly, there is social demand, as birthing centres have to turn down many requests every year. But dialogue with some health professionals, especially obstetrician-gynaecologists, is often difficult; this disagreement on the concept of obstetric violence prevents the possibility of discussion.

Birth centres could contribute to changing this vision of childbirth, that risk is inherent, and to open up discussions and changing the paradigm of a science of obstetrics based on risk. But these birthing centres are controversial in France. They give rise to passionate debate and this issue of giving birth without the presence of an obstetrician and a medical team and without technology remains taboo in France.

121 Le Ray et al. (2021).

2.10 Conclusions and recommendations

2.10.1 Achievements and lessons

1. **Feminist activist circles and social networks** have played a **key role in reporting obstetric violence** and raising awareness in the general population.
2. **Two institutional reports** were **published in 2018** following the **growing public and media mobilisation** on the issue and are significant references in the field of obstetric violence: the HCE report and the report of the French National Academy of Medicine.
3. **Two associations play a central role in denouncing obstetric violence** and supporting women and families who have experienced it: **CIANE,** created in 2003, the leading patient association in the field of perinatal health; and the collective **StopVOG**, created in 2017. They have contributed to putting pressure on institutions to define obstetric violence and on the government to widen the options of locations for delivery for women, e.g. by opening birthing centres.

2.10.2 Challenges

1. There is **no consensus on obstetric violence in France** and the topic generates controversy and debate, particularly within the medical community.
2. There is **no legal definition and no specific law** in France on obstetric violence.
3. **Research** on the conditions and experiences during gynaecological and obstetric care and during childbirth **are scarce and there is no statistical data measuring the extent of obstetric violence** in France. Conducting such research from the perspective and experience of women is an urgent and necessary challenge, including with socially vulnerable and marginalised women.
4. In contrast to other European countries, **the possibility of experiencing childbirth outside the institution of hospitals remains very limited** and is still perceived as dangerous and irresponsible.
5. There are **few initiatives to raise awareness and train health professionals** in France.
6. Deconstructing **the obstetric paradigm based on the notion of risk is very difficult** in France, particularly because of disagreements over the concept of obstetric violence within the medical community.
7. **Birth centres could have contributed to changing this vision of childbirth**, that risk is inherent, and **to open up discussions and changing the paradigm** of a science of obstetrics based on risk (in addition to giving more choice and autonomy to women). But these birth centres are very controversial in France, where obstetrics is highly medicalised.

2.10.3 Recommendations

1. **Support associations** that address obstetric violence, as they play a central role in lobbying the government and institutions and contribute greatly to the recognition of this issue as a public health problem.
2. **Implement a national media campaign to better inform women of their sexual and reproductive rights**, including during gynaecological consultations and during childbirth and especially on free informed consent.
3. **Support academic research on obstetric violence**, including **statistical surveys on women's experiences** during obstetric care and childbirth and qualitative research to better understand obstetric violence from the perspective of women. Such research will make it possible to better define and frame obstetric violence, taking into account its subjective dimension.
4. **Bring the issue of obstetric violence (and more broadly of gynaecological violence) into the legal domain** by setting a legal framework and providing a legal definition of this violence; and **consider penal solutions** when, during gynaecological care and delivery, consent has not been sought and when the patient's choice and integrity have not been respected.
5. **Expand the range of birthing options** by opening more birthing centres throughout France and in the overseas departments.
6. **Open a debate on home birth**, bringing together midwives, including those who perform home births, obstetrician-gynaecologists and researchers, in order to better assess the risks and possible alternatives to the current technicalisation and medicalisation of childbirth, in line with social demands.

3 THE NETHERLANDS by Rodante van der Waal and Marit van der Pijl

3.1 Executive summary and overview

Dutch maternity care is organised in a different way than in other countries. The system is divided into **primary midwife-led care and obstetrician-led care**. In the case of a **low-risk pregnancy, women receive midwife-led care** in the community by a primary care midwife. **People can choose to give birth either at home, in a birth centre or in a hospital with the primary care midwife** as the responsible care provider. Primary care midwives are therefore a strong independent professional group in the Netherlands. In case of **risk factors or complications during pregnancy or labour, women are referred to obstetrician-led care,** where they are taken care of by nurses, hospital-based midwifes, obstetric residents and obstetricians or obstetric registrars. This makes **the Netherlands a unique setting to study obstetric violence through a range of maternity care practices.**

Obstetric violence exists in both midwifery and obstetric care. Since **2020**, the number of **publications on obstetric violence** in the Netherlands is **increasing**. Five studies are included in this report; one quantitative and four qualitative studies. There is one important **activist organisation** in the Netherlands that focuses on obstetric violence: the **Birth movement** (*Geboortebeweging*). On the basis of this case study report, **five recommendations are made**: to make decentralised autonomous midwifery care possible to give pregnant people control over their care; to make sure a guideline on care outside of the normal guidelines is developed to ensure people's freedom to design their own care plan; to address and tackle the problems of obstetric violence and obstetric racism at the same time; to teach all birth professionals extensively about obstetric violence and obstetric racism; and to create awareness on multiple levels of the obstetric system.

3.2 Definitions and references

Obstetric violence (translated: *Obstetrisch geweld*) **is not a common term** in the **Dutch** context. The Royal Dutch Organisation of Midwives (KNOV) and the Dutch Society for Obstetrics and Gynaecology (NVOG) both do not mention the term nor synonyms of the term within their official documents, statements, or guidelines.

Before 2020, scientific articles covering Dutch people's traumatic birth experiences had already **acknowledged the existence of obstetric violence**. Factors such as a lack of informed consent, lack of communication and unilateral decision-making are reported. However, neither the term obstetric violence nor a

synonym was mentioned.[122] Recent and forthcoming articles on the occurrence of obstetric violence in the Dutch context do mention the term or the synonym 'disrespect and abuse' (D&A).[123]

There are **two** important **independent foundations** that **use the term 'obstetric violence'**. The **Birth Movement** (*Geboortebeweging*) are the main activists fighting for birth rights in the Netherlands and use the term as a regular part of their discourse to describe injustice in childbirth.[124] They use the term on their website and on their active Facebook page. Furthermore, they use the term in their actions and they teach classes in midwifery and medical schools on 'care outside of regular guidelines and respectful maternity care', in which the term 'obstetric violence' is also mentioned. In 2016, the Birth Movement initiated a campaign in which women were asked to share their experiences with maternity care in the Netherlands on social media. This campaign is also known as #rosesrevolution or #breakthesilence, previously initiated in several other countries. The Dutch campaign evoked public and media attention, as a large number of women shared their stories.[125] Another important foundation is the **Foundation for Birth Trauma** (*Stichting Bevallingstrauma*), which is the most well-known organisation on birth trauma in the Netherlands and has a long entry on obstetric violence as a cause of traumatic birth on their website.[126]

The term 'obstetric violence' has also **appeared in several media channels**, for instance in the Dutch newspaper the General Daily (*Algemeen Dagblad*)[127] and on Dutch public radio channel 1 (*NPO1*).[128] Brainwash, a well-known cultural platform, has an article on obstetric violence on their website and is making a short informative documentary on the term (*forthcoming*).[129] The website VICE published an article mentioning the term.[130] The midwifery platform, The Wise Voice (*Het Vroede geluid*), has a 'long read' on obstetric violence and published an informative video on the term.[131] The magazine, Baby on the Way (*Baby op komst*), for pregnant people made by midwives has a webpage on obstetric violence on their website.[132] The magazine for professional birth workers, Early (*vakblad Vroeg*), has an article on obstetric violence as well.[133] However, there are also several media items in which clearly topics related to obstetric violence are discussed, but the term is not mentioned, for example an item of RTL news.[134]

122 Hollander et al. (2017); Fontein, et al. (2018a, 2018b).

123 van der Pijl et al. (2021, 2022); van der Waal (2021, 2022a, 2022b); van Nistelrooij & van der Waal (2019); van Hassel et al. (2023); van der Waal (forthcoming a, forthcoming b).

124 https://www.geboortebeweging.nl

125 https://www.facebook.com/search/photos/?q=geboortebeweging&__tsid__=0.6421076819347953&__epa__=SERP_TAB&__eps__=SERP_PHOTOS_TAB.

126 https://stichtingbevallingstrauma.nl/obstetrisch-geweld-2-0/.

127 https://www.ad.nl/gezin/geen-knip-geen-meting-geen-inwendig-onderzoek-nee-zeggen-tijdens-je-bevalling-mag~a16281ab/?referrer=https %3A %2F %2Fwww.google.com %2F.

128 https://open.spotify.com/episode/2lmwGTpRq68WHPgKE622Ny.

129 https://www.brainwash.nl/programmas/brainwash-zomerradio/seizoen-2022/rodante-van-der-waal.html.

130 https://www.vice.com/nl/article/gydv94/hoe-vrouwenrechten-grof-geschonden-worden-in-de-nederlandse-verloskamers.

131 https://vimeo.com/640933816.

132 https://babyopkomst.nl/news/obstetrisch-geweld/.

133 https://www.vakbladvroeg.nl/omgaan-met-geweld-tijdens-de-bevalling/.

134 https://www.rtlnieuws.nl/lifestyle/artikel/5201166/genoeggewegen2020-vrouwen-delen-hun-bevalling-strauma-ik-riep-hou-op-ik.

Based on the personal experience of the authors in the professional context **of primary care midwives** and doulas, **the term obstetric violence** is more common and **well-known than in the professional environment of obstetrician-led care.** The **discourse, vocabularies and understanding of the process of birth** and its cultural context **remains quite distinct between the two**.

There has been discussion on the term in the Netherlands for two reasons. The first is the same as practically everywhere else: birth workers tend to react defensively and the term is considered provocative. Therefore, **some choose to stick with the phrasing of WHO: 'disrespect and abuse' or 'mistreatment'**.[135] The second one is more context-specific and has to do with the translation. In the Netherlands, the word '*verloskunde*' is used as the more common word for obstetrics, although a literal translation of obstetrics ('*obstetrie*') does exist. This is confusing, because '*verloskundige*' is also the newer gender-neutral term for midwife – '*vroedvrouw*' is the traditional word. Since midwives still have a strong and leading position in the Netherlands, there are very few doctors who only specialise in obstetrics. Most specialised doctors involved in pregnancy and childbirth are gynaecologists, with obstetrics belonging to their specialisation. This is different than in most other countries. Since it is not a separate specialisation, 'obstetrics' is hence not a commonly used word in the Netherlands. Since the Dutch maternity care system is divided between primary care and secondary care, primary care is mostly characterised as '*verloskundige zorg*' (midwifery care) and secondary care as '*gynaecologische zorg*' (gynaecological care). Five years ago, there were hence discussions in activist circles if they should call obstetric violence '*verloskundig geweld*' (midwifery violence), '*gynaecologisch geweld*' (gynaecological violence), or '*obstetrisch geweld*' (obstetric violence). Because gynaecological violence is already indicative of another kind of violence and because '*verloskundig geweld*' (midwifery violence) implies that it only happens within independent midwifery, while it actually happens less in independent midwifery.[136] Therefore the activists from the birth movement stuck to the term *obstetrisch geweld* (obstetric violence) – also to be understood better internationally.

The **term 'obstetric racism' or 'racism in maternity care', an important counterpart of obstetric violence, has appeared in several media**. In the renowned journal, Free Netherlands (*Vrij Nederland*), and on Dutch public radio channel 1, interviews with midwife Bahareh Goodarzi were recently published on obstetric racism and structural inequality in Dutch maternity care.[137] Goodarzi's academic research also contributes to greater awareness of inequity in Dutch maternity care, both professionally and publicly.[138] Midwife Pia Qreb shared her experiences on the acclaimed feminist podcast platform, Sauce (*Dipsaus*), and in

135 Please see See van der Waal et al. (2022b) for a more thorough discussion on this problem with the terminology.

136 There is no data yet to support this claim. However, this is the experience of the first author of the case study, who was trained in both contexts, and this conclusion has come out of her PhD research, a qualitative study with 30 participants. A Dutch study does show that women who give birth at home in midwife-led care experience more respect, privacy, communication and autonomy during labour and birth (Van der Pijl et al., 2021). Currently, analysis is being performed to investigate the occurrence of obstetric violence in midwife-led care and obstetrician-led care. Here, it is important to consider that in midwife-led care, labour and birth are more often uncomplicated compared to in obstetrician-led settings.

137 https://www.vn.nl/geboortezorg-gelijk/.

138 https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/ras-en-etniciteit-registreren-in-de-zorg-een-precaire-kwestie.htm.

the journal *Lovel*.[139, 140]

3.3 Data collection and evidence on obstetric violence

3.3.1 Empirical evidence

Qualitative evidence

Four distinct qualitative studies that specifically use the term 'obstetric violence' were done in the Netherlands, all in recent years: a qualitative content analysis[141] of an activist campaign on obstetric violence; a cross-cultural thematic analysis between the Netherlands and South Africa on the effect of obstetric violence on student midwives and doctors;[142] a thematic analysis (conducted in 2020–2021) of 31 in-depth interviews and 12 focus groups with mothers, midwives, midwives in training and doulas on obstetric violence;[143] and an auto-ethnography (conducted in 2021–2022) on the epistemic nature of obstetric violence.[144]

In 2020, a qualitative content analysis was performed to **investigate the stories women shared in the #breakthesilence campaign of the Birth Movement** (as described above).[145] The study aimed to determine what types of disrespect and abuse were described in the stories, based on the existing typology of Bohren et al. (2015) and to gain a more detailed understanding of the experiences. In total, 438 stories were investigated. Situations of ineffective communication, loss of autonomy and lack of informed consent and confidentiality were the most commonly mentioned. The more detailed analysis **revealed five main themes:** 'Lack of informed consent'; 'Not being taken seriously and not being listened to'; 'lack of compassion'; 'the use of force'; and 'short and long-term consequences'. These situations were often described in combination with feelings such as a lack of or losing control, fear, being objectified and being humiliated. 'Left powerless' was identified as the overarching theme: women felt that power was taken away from them, or they experienced difficulties maintaining control due to situations that occurred.[146]

In 2020–2021, a cross-cultural thematic analysis was done on **the effect of obstetric violence and obstetric racism in the training of midwives and doctors** in the Netherlands and South Africa. Students' curricular encounters in two colonially related geopolitical spaces, South Africa and the Netherlands, were amplified to highlight global systemic tendencies that push students to cross ethical, social and political boundaries in relation to the mother they are trained to care for. Obstetric violence was understood as a fundamental part of students' rite of passage to become professionals. It was asserted that the embedment of obstetric violence in their rite of passage ensures the reproduction

139 https://www.dipsaus.org/exclusives-posts/2020/7/18/institutioneel-racisme-in-de-geboortezorg.

140 https://tijdschriftlover.nl/english/inequity_in_dutch_healthcare_a_series; https://tijdschriftlover.nl/english/inequity_in_maternity_care; https://tijdschriftlover.nl/english/inequity_in_preventive_care.

141 van der Pijl et al. (2020).

142 van der Waal et al. (2021).

143 van der Waal et al. (forthcoming b).

144 van Hassel et al. (2023).

145 van der Pijl et al. (2020).

146 van der Pijl et al. (2020).

of the modern obstetric subject, the racialised mother and institutionalised violence worldwide. Drawing on Davis-Floyd's definition of the rite of passage, the same characterisation of the three stages of the rite of passage were used. The following **violent instances within the rite of passage were identified that eventually lead to the reproduction of obstetric violence**: in the stage of separation: 1) emotional isolation; and 2) having to adapt the goals, norms and values of the obstetric institution that instrumentalise the mother; in the stage of transition: 3) establishing subjectivity through assertiveness, competition and learning at the cost of mothers; 4) colluding in explicit obstetric violence, obstetric racism and sexual violence; and 5) traumatic experiences; and in the stage of integration: 6) complicity: balancing guilt with numbness; and 7) responsibility at the cost of mothers.[147]

In 2020 and 2021, a qualitative study on obstetric violence was conducted to get a better sense of **the root causes of and ways of resistance to obstetric violence** in the Netherlands based on the epistemic standpoints of those directly involved; 31 participants were included: 10 mothers, 11 midwives, 5 midwives in training and 5 doulas. Data was collected in three rounds: individual interviews, homogenous focus groups and heterogenous focus groups. The data analysis was done through Thematic Analysis, informed by Care Ethics, Abolition Feminism and Critical Midwifery Studies. **Two main themes were established**. The first was 'institutionalised separation' with the subtheme's 'expropriation', 'carcerality' and 'violence'. Institutionalised separation was understood to be the separation of multiple relations of the pregnant person, i.e. with a partner, a community of care, their midwives and a consequent experience of isolation and loneliness. The second main theme indicated the strategy of the participants affected by obstetric violence, hence also professionals, to resist it and was coined 'undercommoning childbirth' with subthemes 'fugitive planning', 'anarchic relationality' and 'abolition'. 'Undercommoning' means the formation of an underground commons of knowledge, mutual aid and radical care. The aim of the second theme is to reconstitute or 'heal' the relationality that was broken through institutionalised obstetric violence and thus to resolve the experience of isolation.[148]

In 2022, an **auto-ethnographic study** was done to investigate the **epistemic component of obstetric violence**. This is the first study on obstetric violence in the Netherlands that specifically centres epistemic injustice as a major part of obstetric violence. Through **a narrative analysis of four auto-ethnographic experiences with birth and miscarriages** in the Netherlands, **four forms of epistemic injustice** in Dutch reproductive care were laid bare and analysed through the international theoretical literature on the subject: 1) hermeneutic injustice; 2) testimonial injustice; 3) wilful hermeneutic ignorance; and 4) gaslighting.[149]

Quantitative evidence

One quantitative study on obstetric violence was conducted in the Netherlands.[150] In order to obtain more information on the prevalence, a survey study was performed in 2020 to investigate: (1) how often women experience disre-

147 van der Waal et al. (2021).

148 van der Waal et al. (forthcoming b).

149 van Hassel et al. (2023).

150 van der Pijl et al. (2022).

spect and abuse during labour and birth in the Netherlands; (2) how frequently they consider such experiences upsetting; (3) which respondent characteristics are associated with those experiences of disrespect and abuse that are upsetting; and (4) the associations between upsetting experiences of disrespect and abuse and women's overall labour and birth experiences. The survey consisted of 37 questions divided over 7 categories based on existing literature and the local context. The second part of the survey specifically focused on informed consent for different procedures during labour and birth (discussed below in Section 7.3.2). Over 13 000 women participated in the survey, of which 12 239 were suitable to be included in the data analysis. The results are reported in terms of the relevant aim of the study:

*(1) How often do **women experience disrespect and abuse during labour and birth** in the Netherlands?*

54.4 % of respondents reported at least one form of disrespect and abuse. 'Lack of choices' (39.8 %) was reported most, followed by 'lack of communication' (29.9 %), 'lack of support' (21.3 %) and 'harsh or rough treatment/physical violence' (21.1 %). The table below gives an overview of the prevalence per category.

*(2) How frequently do they consider such experiences **upsetting**?*

36.3 % reported at least one form of upsetting disrespect and abuse. Wide variation was found in how frequently certain types of disrespect and abuse were considered upsetting, ranging between 25 % and 100 % per situation. The table below gives an overview of how often different categories were referred to as 'upsetting'.

Table 1: Experiences of disrespect and abuse during labour and birth per category

	Not experienced	Experienced		
	n (% of total)	*Total experienced, n (% of total)*	*Not upsetting, n (% of experienced)*	*Upsetting, n (% of experienced)*
Emotional pressure	11 870 (97.0)	369 (3.0)	50 (13.6)	319 (86.4)
Unkindness/verbal abuse	10 941 (89.9)	1 226 (10.1)	193 (15.7)	1 033 (84.3)
Harsh or rough treatment/physical violence	9 648 (79.9)	2 429 (21.1)	872 (35.9)	1 557 (64.1)
Lack of communication	8 350 (70.1)	3 562 (29.9)	1 024 (28.7)	2 538 (71.3)
Lack of support	9 260 (78.7)	2 498 (21.3)	362 (14.5)	2 136 (85.5)
Lack of choices	6 957 (60.2)	4 602 (39.8)	2 355 (51.2)	2 247 (48.8)
Discrimination	11 426 (99.2)	94 (0.8)	11 (11.7)	83 (88.3)

Source: van der Pijl et al. 2022.

*(3) Which **respondent characteristics** (age, ethnicity, educational level and primiparity) are associated with those experiences of disrespect and abuse that are upsetting?*

Primiparity and a migrant background were risk factors for experiencing upsetting disrespect and abuse in all seven categories. Higher age decreased the risk of disrespect and abuse in the categories 'Harsh or rough treatment/physical violence', 'lack of communication' and 'lack of choices'. Women with a higher education level had a higher chance of experiencing a lack of choices.

*(4) What is the **association between upsetting** experiences of disrespect and abuse **and women's overall labour and birth experiences**?*

In total, 79.1 % of respondents reported a positive or very positive experience, 11.9 % a negative and 9 % a very negative or traumatic birth experience. Upsetting disrespect and abuse was found to have a strong impact on the overall labour and birth experience. With every additional category of experiencing upsetting disrespect and abuse, the number of (very) positive labour and birth experiences decreases and the number of very negative ones increases.

The groups of women most affected, whether different groups experience different forms of obstetric violence and different prevalence rates

All the above studies indicate that marginalised people, mainly migrants, people of colour, people with a migration background and people with a language barrier suffer more often and more severe forms of obstetric violence. Apart from the cross-cultural study on obstetric violence and obstetric racism in students' training,[151] none has specifically focused on obstetric violence and the intersection with racism. The 2022 quantitative study determined that having a migration background is a risk factor for obstetric violence.[152] A distinct form of obstetric violence, 'obstetric racism', is frequently reported by people of colour, mostly by Black people.[153] Obstetric racism can be understood as being located at the intersection of what is commonly understood as obstetric violence and medical racism.[154] The work of Bahareh Goodarzi and Pia Qreb (see Section 7.2) lays bare structural, institutional, obstetric racism in the Netherlands and new numbers indicate that people with a migration background suffer higher numbers of maternal and neonatal mortality and morbidity – indicating severe diagnostic lapses and other forms of obstetric racism (see below for more information).

3.3.2 Relevant manifestations

The quantitative study on obstetric violence in the Netherlands showed that **the category 'lack of choices' (39.8 %) was reported by the highest share of women**, followed by 'lack of communication' (29.9 %) and 'lack of support' (21.3 %) (see the table above).[155] In terms of specific situations, 'Not being free to decide the position to give birth in' (lack of choices) was the situation indicated by the most women (25.3 %), followed by 'feeling like necessary information was

151 van der Waal et al. (2021).

152 van der Pijl et al. (2022).

153 van der Waal et al. (2021); van der Waal (forthcoming a, b).

154 Davis et al. (2022).

155 van der Pijl et al. (2022).

not provided' (lack of communication, 20.9 %).

The qualitative 2020–2021 thematic analysis of interviews and focus groups with mothers, independent midwives, midwives in training and doulas reported **the types of obstetric violence most often experienced** as 1) **unconsented and/or unwarranted and/or unwanted vaginal examinations**; 2) epistemic injustice, mainly epistemic **manipulation in the form of playing the dead baby card** (a form of shroud waving where the risk to the baby's life is exaggerated when a pregnant person does not consent to a procedure); 3) **physical violence**, consisting of interventions without consent; 4) **penetrative violence**, i.e. violence that is linked to, or reminiscent of, rape or sexual assault, such as (mostly listed) episiotomies, pelvic floor support (or 'pelvic massage') and vaginal examinations; 5) **forced interventions** that are indirectly physical, such as a transfer to the hospital without consent or knowledge of other options, or directed pushing against one's will; forced interventions that are physical, such as CTG monitoring, oxytocin injection after birth, the baby having a foetal scalp electrode, breaking of the amniotic sac without knowledge, lying on one's back; and 6) **obstetric racism** (see below for a description of obstetric racism in the Netherlands).[156]

The 2021 study on the effect of obstetric violence on students' training reported the types of obstetric violence most often experienced as: **lack of informed consent, specifically regarding students' participation in the care for birth and forced interventions/physical abuse** (mostly vaginal examinations, episiotomies and pelvic floor support), and verbal abuse (mostly racist and paternalising remarks).[157]

The analysis of the #breakthesilence campaign showed that in almost half the stories women report being **ignored and not being taken seriously**. For example, women reported caregivers not talking *to* but *about* them while being in the room. A **lack of compassion** was also mentioned in half of the stories, mostly in situations where women expressed pain or exhaustion to the care providers. Lack of informed consent was also an important theme: in over a quarter of the stories, women reported at least one **act taking place without their consent**. In some cases, the act was only announced by the care providers, while in others, the act took place without any comment or consultation. In around a fifth of the stories, a form of use of force was described, mostly during the active stage of labour and in relation to interventions being carried out.[158]

Lack of consultation or consent is a reoccurring subject regarding obstetric violence in the Netherlands. The quantitative survey showed that 11.8 % of the respondents reported a (medical) intervention being performed without clear permission in advance, while 3 % experienced a medical intervention that was continued despite requesting for it to be stopped.[159] The second part of the quantitative survey specifically focused on informed consent, investigating 10 common procedures during labour and birth, asking for each procedure if the respondents underwent the procedure, if they were asked for consent, if the information they received was sufficient and, if they did not give consent, whether they found this upsetting.[160]

156 van der Waal (forthcoming b).

157 van der Waal et al. (2021).

158 van der Pijl et al. (2020).

159 van der Pijl et al. (2022).

160 van der Pijl et al. (forthcoming).

The **auto-ethnography on epistemic injustice** reports hermeneutic and testimonial injustice, as well as gaslighting and wilful hermeneutic ignorance. Hermeneutic injustice is when **a pregnant person does not have the right knowledge or discourse to understand and explain the obstetric violence being done** to them. Testimonial injustice is when a pregnant person is not believed or not taken seriously with regards to the violence done to them. Gaslighting is when the knowledge of the pregnant person is doubted in such a way that it is insinuated that the pregnant person is crazy or a bad mother, until they start to doubt themselves. Wilful hermeneutic ignorance is when facts and options are wilfully kept from a pregnant person.[161]

Timing of obstetric violence

The qualitative 2020–2021 thematic analysis of interviews and focus groups with mothers, midwives, midwives in training and doulas shows that although the most severe and traumatic forms of **obstetric violence happen during childbirth, such violence is almost never an isolated incident**. The participants have difficulty describing when obstetric violence begins and ends, as it often builds up during pregnancy – in authoritative discussion on care, epistemic injustice, not being taken seriously, a lack of choices in preparation for birth, etc. – to 'culminate' during labour and persist post-partum. [162]The same was found in the 2021 study on the effect of obstetric violence on students' training, which found that the hierarchical, authoritative structure of the obstetric system in combination with many incidents of obstetric violence or disrespect eventually culminate into a more traumatic experience during childbirth.[163]

With regards to **epistemic injustice, obstetric violence seems to happen as much during as before or after labour**. Examples from the auto-ethnographic study are an episiotomy without knowing *during* birth, lack of knowledge of other options of treatment *during* miscarriage, playing the dead baby card *before* birth and not believing the amount of pain someone is in *after* miscarriage. Almost all the stories shared in the #genoeggezwegen campaign covered experiences during labour and birth or the post-partum period. A combination of situations (e.g. a moment during pregnancy and a moment during labour and birth) also occurred.[164]

The quantitative study on obstetric violence covered situations during labour and birth, defined as **from the onset of labour until one hour after the birth of the placenta**. However, questions were also asked about information provision, which could be interpreted as receiving enough information about a certain topic related to labour and birth.[165]

Obstetric racism

There are **seven dimensions** (see the figure below) of **obstetric racism**: 1) diagnostic lapses; 2) neglect, dismissiveness or disrespect; 3) intentionally causing pain; 4) coercion; 5) ceremonies of degradation; 6) medical abuse; and 7) racial

161 van Hassel (2023).

162 van der Waal et al. (forthcoming b).

163 van der Waal et al. (2021).

164 van der Pijl et al. (2021).

165 van der Pijl et al. (2022).

reconnaissance.[166] Obstetric racism contributes both to the frequency and severity of obstetric violence, and also affects birth outcomes. In the Netherlands, people belonging to an ethnic minority have a significantly increased risk of perinatal mortality.[167] All forms of obstetric racism are documented in the Netherlands.

Figure 2: The seven dimensions of obstetric racism

The cross-cultural study on obstetric violence in students' training clearly shows that people of colour suffer from obstetric violence more often and more severely, specifically in the form of obstetric racism.[168] Regarding the dimensions of obstetric racism, students report **medical abuse**, that they are more often allowed to practice on people of colour, that people of colour are less often asked for consent for internal vaginal examinations, and that they are not informed that the one who conducts the examination or procedure is a student. The study also reports **coercion**, mostly overlapping with general forms of obstetric violence such as vaginal examinations without consent, but with the additional harmful

166 Davis et al. (2022).

167 Achterberg et al. (2020).

168 van der Waal et al. (2021).

aspect of a woman having a language barrier and hence not understanding what is happening.[169]

The qualitative 2020–2021 thematic analysis of interviews and focus groups with mothers, midwives, midwives in training and doulas reports **diagnostic lapses** when it comes to Black women, in the form of a lack of knowledge about pregnant and birthing bodies apart from white people's bodies and in the form of the determination of care plans based on racial bias (either due to personal prejudices or due to prejudices embedded in protocols). It furthermore reports **coercion** in the form of using medical instruments (such as bigger-sized needles and specula) when the pregnant woman specifically indicates she needs a smaller size. It also reports **neglect, dismissiveness and disrespect** in situations where white midwives speak to the white at-home maternity nurse, rather than to the Afro-Dutch mother. Both Black mothers and care workers have a hypervigilant attitude regarding their own care and the care of their clients, attesting to the efforts of **racial reconnaissance**.[170]

Qreb's thesis on obstetric racism shows discrimination against both pregnant people and care workers of colour. Care workers of colour reported having been refused to be allowed to care for people and being treated with a negative attitude by pregnant people. Pregnant people of colour were treated with assumptions, prejudice, systemic discrimination, negative communication and getting inferior care.[171] Qreb also shared her own experiences with obstetric racism on Twitter, which recounted[172] care workers **intentionally causing pain** in the form of refusal of pain medication, prioritising white women above Black women in administering pain medication. Qreb also reports **ceremonies of degradation** in the form of the many racist and paternalising remarks.[173]

In the study on #breakthesilence, 7 of the 438 stories were classified as discrimination based on sociodemographic characteristics, which includes discrimination based on ethnicity, race or religion.[174] Although this number is low, it is likely that #breakthesilence had an underrepresentation of people with a migration background.[175]

The quantitative study shows that 0.3 % of the respondents experienced discrimination based on race, ethnicity, cultural background or language. Although this number is low, the study also had an underrepresentation of respondents with a migration background. The survey was available in English and Dutch, which made it difficult for non-English and non-Dutch speakers to participate. Furthermore, when compared to respondents who themselves and both their parents were born in the Netherlands, it was seen that respondents with a migrant background had higher odds of experiencing obstetric violence in all categories. The odds ratios for experiencing discrimination were 3.4 and 5.9. For all other categories, odds ratios ranged from 1.2 to 2.1 (a few of them not reaching significance).[176]

Manifestation in different healthcare settings (i.e. hospital, clinics, homebirth,

169 van der Waal et al. (2021).

170 van der Waal et al. (forthcoming b).

171 Qreb (2021).

172 https://www.thebestsocial.media/nl/kraamzorg-racisme-twitter/

173 Qreb (2021).

174 Bohren et al. (2015).

175 van der Pijl et al. (2020).

176 van der Pijl et al. (2022).

maternity home); different health professionals (i.e. midwives or gynaecologist), other.

The qualitative analysis of the #breakthesilence campaign showed that different care providers were mentioned in the stories.[177] **Midwives and obstetricians were mentioned by women in roughly equal numbers**, indicating that women experience disrespect and abuse throughout the Dutch maternity care system. Based on our personal experience (the first author is trained in the Dutch obstetric system) and on the basis of scientific indications, we believe, however, that **obstetric violence is more severe and widespread in secondary obstetric-led care, by midwives, nurses and doctors**.

The occurrence of disrespect and abuse per healthcare setting based on the data of the survey study[178] is currently being investigated. Results are expected in 2023. However, a study on experienced interaction between client and care provider during labour and birth in the Netherlands showed that women who give birth with a community midwife at home experience more optimal respect, communication, autonomy and confidentiality in the interaction compared to women who give birth at the hospital with a (resident) obstetrician or hospital-based midwife.[179]

While **midwifery-led care is internationally often seen as a solution to obstetric violence**, we see in the Netherlands that this only counts for truly independent midwives who have the time to care for their clients and do not suffer under the same institutionalisation of maternity care as obstetric institutions. Although there is a big division between midwifery-led and obstetric-led care and obstetric violence does occur less in the former care, there is again a major difference between truly alternative caseload midwives who put the needs of pregnant people first and bigger group practices that are part of the 'regular care' system in the Netherlands.

In the qualitative 2020–2021 study, **most mothers and midwives had experiences with obstetric violence in either 'regular' midwifery care or in the hospital**, after which they looked for more alternative midwives for their second pregnancy (even when these women did not consider themselves to be 'alternative').[180] Midwives regularly burn out in regular midwifery care practices and then start more alternative small-scale continuity of care practices.[181] While **midwifery-led care thus certainly works to prevent the occurrence of obstetric violence**, at this moment in time regular bigger midwifery practices are so integrated in the obstetric system that it does not fully protect against obstetric violence. It is therefore of the utmost importance that we design midwifery-led care in such a way that it truly adheres to a midwifery philosophy, namely one of relationality and continuity of care. If the time is not granted to truly be with women, the organisation is still too similar to obstetric care, with the only difference that it is carried out by midwives and the reproduction of obstetric violence will not be resisted.

177 van der Pijl et al. (2020).

178 van der Pijl et al. (2020).

179 van der Pijl et al. (2021.)

180 van der Waal et al. (forthcoming b).

181 van der Waal et al. (forthcoming b).

3.4 Root causes of obstetric violence

Professionals

It is important to note that **occurrences of obstetric violence should not be mistaken for the prevalence of their intent: on the basis of personal experience**, we believe that in the overwhelming majority of situations, care providers do not intend to harm their patients. Although less researched, a root cause of obstetric violence is neoliberal capitalism that leads to a lack of capacity in midwifery and obstetrics, burned-out care workers and care workers who do not have the time and the support to process their own trauma. Care providers work hard under very stressful conditions to have positive health outcomes for both mother and baby. They are often not aware that their acts can be interpreted as upsetting and aim to do their best, in the cases of nurses and midwives, for little pay for a job with a high workload involving weekend, holiday and night shifts with a high level of responsibility in a system that is suffering under lack of capacity and staffing problems.

There are **major differences in the perspectives of care providers and pregnant people**. In relation to informed consent, for instance, a study on performing episiotomies showed that care providers do value women's autonomy but think that ultimately the decision for the episiotomy is made by the care provider. Care providers see the trustful relationship between them and their patient as the basis of informed consent and consent is mostly based on opting out. Care providers also say that informed consent in the second stage of labour can be difficult to obtain.[182]

Currently, the perspectives and experiences of care providers in terms of obstetric violence is not researched enough and requires more attention. We understand obstetric violence to not be a problem of healthcare professionals as individuals but institutionalised violence which is facilitated by the obstetric system. At the same time, care providers generally decide when interventions are needed, leading to a lack of information for and involvement by women who give birth. Informed consent is still not a daily routine process and there is a lack of education on the subject. Lack of awareness about obstetric violence, resistance again critical inquiry into it and the negative attitude of care providers working within the obstetric system remain major causes of obstetric violence. There is some improvement, however, with increasing emphasis on patient-centred care and shared decision-making.

The Dutch obstetric system

Within Dutch maternity care, **gynaecologists are the ultimate authorities**. Even though there is a strong system of autonomous midwifery care, their care if still often defined by **a top-down hierarchical system in which doctors ultimately decide when someone should be referred to the hospital**. If a midwife does not refer someone to the hospital when the hospital thinks they should, midwives get criticised. As often with hierarchical cultures in maternity care, pregnant people find themselves at the bottom of the hierarchy.

Overall, **the system** can be described as **very risk averse**. There is a difference of opinion on which professional decides on risk selection. This often leads to

182 Seijmonsbergen-Schermers et al. (2021).

debate between doctors and midwives or a lack of clarity in various protocols. For pregnant people this can be very confusing: one moment they are in midwifery care and the next moment they have been taken over by obstetric care – and they have limited control over these referral policies, especially when they do not have much social privilege.[183] Consequently, any pregnant person wishing to take more risks than is recommended in the official protocols is seen as a problem.

The study into students' experiences with obstetric violence shows that **a root cause of obstetric violence is its own reproduction through its strong embedment in students' training**. If students train within a system that is violent and they can only graduate if they are complicit, then the violence logically reproduces itself through the violation and traumatisation of the student. It is important to recognise that the damaging of students through obstetric violence is an essential part of the normalisation and hence the functioning of obstetric violence within the obstetric system-[184]

Underlying structures of institutionalised obstetric violence

Research in the Netherlands uncovers **underlying suppressive structures within the obstetric institution** which are similar to most countries. In the Netherlands, sexism and misogyny are also underlying causes for obstetric violence, as has been advanced in international scholarship on obstetric violence and in the Netherlands most specifically in the auto-ethnography on epistemic injustice wherein epistemic injustice is understood as a gendered form of exclusion and discrimination wherein women, especially mothers, are not considered rational.[185]

In the Netherlands, **the ultimate justification of obstetric violence is the safety of the unborn child**, whether it is really in danger or not, making the life of the child the *prima causa*, or first principle, of the system of obstetrics that becomes almost impossible to challenge: the primacy of the child over the mother. This leads to the authoritative risk aversion and epistemic injustice towards mothers, most notably to the playing of the dead baby.[186]

Less researched underlying suppressive structures that give rise to obstetric violence within the obstetric institution have become manifest as well. The qualitative 2020–2021 thematic analysis of interviews and focus groups with mothers, midwives, midwives in training and doulas, bring to the fore as root causes the 'carceral logic' of the obstetric institution, consisting of the expropriation of pregnant people's knowledge and bodily capacities, their isolation and traumatisation, the fear of punishment and authority located with care providers. For both mothers, as well as midwives, doulas and midwives in training, the institution feels less like a safe space of care and more like a place wherein they get captured through discipline, governance, protocols and punishment. Care workers fear legal repercussions as well as social ones. This forces them to be complicit to the institution and hence disciplines them. Consequently, the relationality within the institution is characterised by mothers as assumed ownership over their bodies, circumscription of agency, regulation of movement, violation of privacy, mistrust, neglect, lack of relationality, lack of trust and enmity. They describe that obstet-

183 Goodarzi (2018, 2020, 2022).

184 van der Waal et al. (2021).

185 van Hassel et al. (2023).

186 van der Waal et al. (forthcoming b); van Hassel et al. (2023).

ric care circumscribes and confines them and punishes them for being difficult. **People's bodies are 'appropriated' and 'handled' through being put on display without consent or being forced to comply**, in a way that holds their bodies and birth captive.[187]

The cross-cultural study on obstetric violence in students' training lays bare the **Dutch history of colonialism as a root cause of structural obstetric racism**. It shows how obstetrics should be understood as a global modern institution through the linkage of two colonially related geopolitical places, namely South Africa and the Netherlands. In both places, the obstetric professional can only constitute itself through engulfing the maternal body as its other, thereby reproducing her racialisation and suppression. All remain, in different ways, excluded from the position of power and subjectivity within the obstetric institution, as all are appropriated into the obstetric subject that constitutes itself through othering the mother. The effect of colonialism is still visible in current day expressions of obstetric racism. [188]

3.5 Consequences of obstetric violence

In the #breakthesilence stories, **short- and long-term consequences following a negative experience of care** were often mentioned, for example: emotional trauma, difficulty in sleeping and being (too) scared to give birth again (tocophobia). The results of the quantitative study showed that 9 % of the women who give birth in the Netherlands have a very negative or traumatic birth experience. [189]This percentage is similar to 10 years ago: Stramrood et al. (2011) found that 9.1 % reported their labour and birth as traumatic. The quantitative study also showed that with every additional experienced category of upsetting disrespect and abuse, the number of (very) positive labour and birth experiences decreases and the number of very negative ones increases. Stramrood et al. (2011) also looked into PTSD following labour and birth, which was found in 1.2 % of the respondents. Although there is some evidence linking obstetric violence to the occurrence of PTSD following labour and birth,[190] Dutch studies are lacking. Martinez-Vazquez et al. (2022) also found a link between obstetric violence and the occurrence of post-partum depression. We want to point out, however, that there can be negative consequences, such as a lack of trust, not being able to have a good birth experience, being betrayed and many other valid experiences that are not captured within the above numbers because they did not lead to trauma. The 2022 quantitative study found that 36 % of people giving birth found something about the way they were treated during childbirth 'upsetting', hence important enough – keeping in mind the enormous amount of normalised obstetric violence – to upset them.[191]

Having a negative experience with care can **lead to a different organisation of care for the next pregnancy.** A study on women's motivations for choosing a high-risk birth setting against medical advice in the Netherlands was mostly due to previous or current negative experiences with care or conflicts in the birth plan. [192] This shows the resilience and creativity of pregnant people and midwives

187 van der Waal forthcoming b).
188 van der Waal et al. 2021).
189 van der Pijl et al. (2022).
190 Martinez-Vazquez et al. (2021).
191 van der Pijl et al. (2022).
192 Hollander et al. (2017).

to organise emotionally safe care on the periphery of obstetric institutions. What is seen as 'safe' and 'high risk' differs from person to person and this differs especially between victims of obstetric violence and the obstetric institution. In the 2020–2021 qualitative study, most mothers who were interviewed successfully organised their care both emotionally and physically safe outside the regular logistics and protocols of the obstetric system.[193]

We know that obstetric violence influences healthcare providers in the form of secondary trauma or secondary tocophobia. We need more research to know how widespread this is in the Netherlands.

3.6 Obstetric violence and Covid-19

There is **no direct evidence on obstetric violence and Covid-19** in the Netherlands. However, there are some studies that looked into location of birth and women's birth experiences with regard to the Covid-19 pandemic period. One study examined women's birth experiences in the Netherlands and the United Kingdom, before and during the Covid-19 pandemic. The results showed that **women who gave birth during the pandemic reported a positive birth experience more often compared to women giving birth pre-pandemic,** despite the fact they reported less support and choice during labour and birth during the pandemic. This difference in experience is explained by the **lower expectations of women during the Covid-19 pandemic**.[194] Another study aimed to examine if the course of pregnancy and birth among low-risk pregnant women in the Netherlands changed during the Covid-19 pandemic compared to pre-pandemic. The results showed that during the Covid-19 pandemic, more women desired and had a home birth.[195] Finally, there are indications that obstetric racism increased during Covid-19. Midwife Pia Qreb reported remarks like 'if our own people cannot have an extra person present during labour, others most certainly cannot'.[196]

3.7 Achievements and challenges

Since 2020, much progress has been made on data collection on obstetric violence. Due to the two PhD-studies dedicated to the topic, extensive data was collected. It is important that both quantitative and qualitative data are collected. When only quantitative data is available, then it remains difficult to understand the exact workings, experiences and system logics that make up obstetric violence. When only qualitative data is collected, though, we have no idea of the scope of the problem. With both types of data collected, we have now made a start in the Netherlands. It is only a start though – the perspective of many involved groups is still lacking, for instance.

We do not have enough research on the intersection of obstetric violence and obstetric racism. And marginalised groups, both in terms of groups with migration backgrounds, as well as groups with a diverse gender identity, are under-represented in both the quantitative and qualitative studies done so far. Currently, there is **limited data on the experience of care providers with obstetric violence**. The 2020–2021 study does take into account the perspec-

193 van der Waal (forthcoming b).

194 Van den Berg (2022).

195 Verhoeven et al. (2022).

196 https://www.thebestsocial.media/nl/kraamzorg-racisme-twitter/

tives of midwives and doulas. [197]However, there are no studies yet on midwives, doctors and nurses working in obstetric-led care. It is essential to obtain their perspectives in order to effectively understand care providers' perspectives and improve obstetric-led maternity care. Another important under-researched perspective is that of **birth companions**: persons supporting pregnant people in labour. Most often this is the partner, but this could also be a family member or a friend. Currently, **their perspectives in terms of negative experiences with care and trauma is under-researched.** Birth companions have an essential role during labour and birth and their perspectives can provide valuable insight into how the birth environment is organised and what ways it can be improved. The only study that takes doulas into account is the 2020–2021 qualitative study.[198]

The **quantitative results** presented in this case study are not based on direct observations of obstetric violence, but are all from women's perspectives. We have to acknowledge that **objective measurement of the issue is difficult**. Both the normalisation of obstetric violence and subjective interpretation can lead to under-representation and overrepresentation of the problem. Also, we have to acknowledge that in **surveys, some women might be more prone to participate compared to others**. To overcome this challenge, the recruitment was specifically aimed on various birth experiences, without emphasis on negative experiences or obstetric violence. Still, when measuring obstetric violence, the characteristics of the study population must be taken into account.[199]

One of the most significant recurring **challenges** is the need to **recognise research outcomes in clinical practice and how to translate them to active changes in the medical setting**. We already know enough to be able to say that obstetric care is not physically, emotionally and psychologically safe enough for people giving birth. In a rich country like the Netherlands, the quality of care should be higher. There is also enough knowledge to know how we must change the system: the focus should be on small-scale relational continuity of care. It is one thing to collect data and draw consequences and another thing to authentically change a system of care.

197 van der Waal et al. (2022).

198 van der Waal et al. (forthcoming b).

199 van der Pijl et al. (2022).

3.8 Relevant initiatives and their impact

3.8.1 Initiatives leading to political action

Relevance of the topic in political and institutional debate

There is **political recognition of obstetric violence**. After the first Dutch #breakthesilence campaign in **2016**, the **Birth Movement created a report** including all the stories that were shared and asking for more attention to the bodily integrity of pregnant women and their right to informed consent. They submitted the report to the Ministry of Health, Welfare and Sport in February 2017, who responded by letter in April 2017, acknowledging the experiences and stating that the patient should be central to and involved in decision-making. However, it was also mentioned that while the advisory professionals acknowledge the problems, they do not believe this is a large-scale problem. Moreover, they argued by law protects all patients, the organisation of maternity care is changing and different parties are working on this. Therefore, the ministry believes that there are enough efforts to improve the position of pregnant people.[200]

To our knowledge, there is **no institutional recognition of the problem of obstetric violence** in the Netherlands. It is **not mentioned in any guidelines, policy documents or vision or mission statements of institutions or organisations of doctors or midwives**. There is **a guideline on maternity care outside the system**,[201] which provides guidance when pregnant women reject recommended care. The guideline states that in these situations, attention and respect for the wishes of the patient is important, without judgement. This is challenging and requires advanced communicative skills. The goal is to inform the pregnant women as much as possible and make sure they understood the information and the available alternatives. The final decision belongs to the pregnant woman. Research shows that the decision to reject recommended care is often due to a negative experience with care during the current or previous pregnancy.[202] Since the Dutch Society for Obstetrics and Gynaecology (NVOG) and the Royal Dutch Organisation of Midwives (KNOV) created **this guideline** on how to care for people who wish to go outside of the regular protocol, it has become **an important tool to resist obstetric violence, as it became easier for pregnant people to arrange care outside of clinical guidelines**.[203] It has become more normalised that people have different wishes. Proof of this improvement is that a requisite for job applications for new midwives in one of the biggest hospitals in Amsterdam is that they 'must like to care for people who wish to go outside of guidelines'. This was unimaginable a few years ago.[204]

200 https://zoek.officielebekendmakingen.nl/kst-31476-20.html.

201 https://www.nvog.nl/wp-content/uploads/2018/02/Leidraad-Verloskundige-zorg-buiten-richtlijnen-1.0-30-11-2015.pdf.

202 Hollander et al. (2017).

203 https://www.knov.nl/zoeken/document?documentRegistrationId=11862017.

204 https://www.werkenbijolvg.nl/vacatures/physician-assistant-klinisch-verloskundige-60801.html.

Degree of recognition of the topic by healthcare providers

To our knowledge, **except for some trainings and masterclasses** (see below), there are, **no official or institutional measures implemented to facilitate health personnel to understand the relevance of the topic** and to understand **roots and manifestations and to prevent obstetric violence**.

Degree of recognition of the topic by the general public and women

In general, **public awareness of the topic is low**. **Pregnant people are more and more aware** of the need for respectful care and the risk of overmedicalisation, but not specifically of obstetric violence. The awareness that is there has not been raised by any institution. It has been raised by scholars, activists, mothers, midwives and doulas, and most effectively by the Birth Movement (*Geboortebeweging*). The #breakthesilence (*#GenoegGezwegen*) campaign continues and receives much media attention. For a few years now, this has been coupled with the action *#TakeResponsibility* (*#HandInEigenBoezem*), wherein healthcare workers confess the obstetric violence they are responsible for or complicit in.

After the first #breakthesilence campaign in 2016, the Birth Movement repeated the same campaign four years later, in 2020. In 2021, they did a variant of this action. This time, the Birth Movement asked women to send a message about their negative experiences to their care provider who was involved at the time. There were two types of cards: the first one was anonymous; women could share their story by writing it on a card and sending it to the care provider. The second card said, 'Let's Talk', inviting the care provider to talk about the experience with the sender of the card and/or with other care providers. Several media channels reported about the campaign.[205, 206] The campaign was met with much resistance from healthcare workers including those who are generally sympathetic to #breakthesilence as it was perceived as an individual attack on (often overburdened) healthcare workers, rather than fighting obstetric violence as a systemic problem. **The Dutch Society for Obstetrics and Gynaecology** (NVOG) reacted with an official response, stating that they **acknowledge women's experience, but doubted that sending an anonymous card is a** constructive solution to the problem. The **Royal Dutch Organisation of Midwives (KNOV) supported the campaign and motivated their members to participate**. In their response, they mentioned obstetric violence as a worldwide phenomenon.[207] In 2022, another action of the Birth Movement was to analyse paternalistic, authoritative and incorrect statements on the websites of hospitals and midwifery practices. This action was effective in that most organisations who were publicly critiqued for their use of language agreed to rewrite their content.

During Covid-19, the midwife Margot van Dijk did a similar action together with the Birth Movement to protest the refusal of a third person, mostly the doula, during labour: #StandUpforWomen (*#Staopvoorvrouwen*). The action was effective in that it reached a lot of media and some hospitals and midwifery practices loosened their policies afterwards. There have been other **small initiatives to raise awareness and there are more and more stakeholders who are**

205 https://www.nu.nl/kind-gezin/6170027/geboortebeweging-roept-op-stuur-de-zorgverlener-een-kaart-na-bevaltrauma.html.

206 https://www.rtlnieuws.nl/nieuws/nederland/artikel/5271337/geboortebeweging-bevalling-trauma-ervaring-ziekenhuis.

207 https://www.knov.nl/actueel/nieuws/nieuwsbericht?newsitemid=45154304.

addressing pregnant people's rights in childbirth and thereby resisting the epistemic injustice in the medical system.

3.8.2 Initiatives to combat obstetric violence

Relevant initiatives to address the topic

Apart from the usual ways institutions facilitate formal complaints, **there are no specific ways to file a complaint about obstetric violence**. The Netherlands does **not** have an **Observatory or similar** body. However, the topic has been addressed in various ways, including by the Birth Movement as described previously. This has proven effective in the sense that they reach thousands of people with their Facebook page and are considered a steady source of resistance (and often regarded as a threat) by the medical establishment. Most people working in obstetrics know what the Birth Movement is and what they stand for.

Relevant initiatives to involve and train health professionals

There are **several trainings and school programmes organised by midwives that use the term**. The training centre, the Northern light (*Noorderzicht*), of Rebekka Visser has a day-long training called 'obstetric violence'.[208] The masterclass programme, Ask the Midwife (*Vraag de vroedvrouw*), of Margot van Dijk has one masterclass devoted to obstetric violence.[209] The training programme, Radical Birthwork (*Radicaal geboortewerk*), by Madyasa Vijber, has one out of six days devoted to obstetric violence and another day on obstetric racism. The 2022 Humanising Birth Summer School, organised by the University for Humanistic Studies, included many lectures on obstetric violence.[210] Radical Birthwork, Ask the Midwife and the Humanising Childbirth Summer School have full days or masterclasses dedicated to the subject of obstetric racism, along with their attention to obstetric violence.

There are also **workshops and trainings that are not specifically about obstetric violence, but that will make healthcare professionals more sensitive to boundaries and respect**, such as the Trauma-Informed Care workshop for healthcare professionals by Joyce Hoek Paula from the Bia Doula training, and Give Birth Better (*Beval Beter*) from gynaecologist Claire Stramrood.[211]
In terms of **education for maternity care providers working in both midwife-led care and obstetrician-led care, it is unknown to what extent obstetric violence is embedded in the curriculum**, though it is likely to be very little. The Birth Movement provides lessons on respectful care and care outside the guidelines one to two times a year in Amsterdam and Groningen. In Rotterdam, there was one class taught about obstetric violence this year by the first author of this case study to students who had never heard of the term within their studies. Due to the increasing attention to the subject, it is likely the topic will receive an increasing amount of attention in the future. It is important that each different education system focus on this topic, as every care provider that is linked to maternity care should acknowledge the problems that could arise from obstetric violence.

208 http://noorderzicht.com.

209 https://vraagdevroedvrouw.nl/masterclass-geboortezorg/.

210 https://rodantevanderwaal.com/summer-school-2022/.

211 https://bevalbeter.nl/zorgverleners/

Relevant initiatives to support women

The **Birth Movement has a 24/7 phone service that will help labouring people in need**. They have a network of midwives throughout the country who can support pregnant people or take over their care. Both the Birth Movement and the Clara Wichmann Foundation support and help victims who want to make legal complaints or go to court.

Foundation Birth Trauma (*Stichting Bevallingstrauma*) supports people who have had a traumatic birth experience. They have a network of specialised psychologists and psychotherapists. In recent years, there are also many independent midwives who have specialised in traumatic birth experiences. We are not aware of any other formal support systems.

There are **many informal ways to get help and who will offer help though and the Birth Movement as well as the network of Collaborative Midwives** (*Samenwerkende vroedvrouwen*) are the places to enter these networks. If someone posts a message on the Birth Movement Facebook page or calls and asks for help, they will be supported. There is a vast not very visible network of doulas, mothers and midwives in the Netherlands who are committed to help pregnant and labouring people get the care they need either during pregnancy, after a traumatic experience, or before getting pregnant again. [212]

Relevant initiatives to deconstruct general assumptions on childbirth

In addition to the initiatives described above, Concerning Maternity, **an academic research network organised by the Care Ethics department of the University for Humanistic Studies, is dedicated to deconstructing the underlying structural causes of obstetric violence and dominant ideologies of motherhood.** The Wise Voice (*Het Vroede geluid*) is a political platform on midwifery with podcasts, interviews and articles critical of obstetric care as it relates to gender, trans masculinity, capitalism, obstetric violence, exclusion and discrimination, inclusivity and diversity. Ask the Midwife (*Vraag de vroedvrouw*) also has articles and masterclasses aiming to deconstruct general assumptions about childbirth, both with regards to childbirth physiology and pathology, as well as with regards to the culture. Regarding obstetric racism, there is a working group on the subject at the midwifery academy Amsterdam, led by Bahareh Goodarzi. Goodarzi also created a working group on the subject of Diversity, Inclusion & Anti-Discrimination at the Royal Organisation for Midwives (KNOV).

212 van der Waal 2022 (forthcoming b).

3.9 Conclusions and recommendations

Make decentralised, autonomous midwifery care possible to give pregnant people control over their care

One of the most important lessons from the Netherlands is with regards to midwifery. While **midwifery-led care is not always free of obstetric violence, its most important contribution to the resistance against obstetric violence** is that it provides pregnant people with a whole, autonomous and diverse care system outside of the institution of obstetrics. Pregnant people in the Netherlands can hence (if they have the knowledge and capacity) relatively easily design and be in charge of the care they want. There are many autonomous independent caseload midwives for instance, that can provide the physically and emotionally safe and accessible, relational continuity of care needed for the humanisation of birth. The existence of **autonomous midwifery care and homebirth gives pregnant people many options for how they want to give birth** and gives them almost **full control over with whom they want to give birth**. As such, it gives them the possibility to practise resistance against obstetric violence *themselves*, rather leave them dependent on the level of respectful maternity care the institution is able to facilitate. It gives them, in other words, a safe way out.

Our **recommendation** would be to **invest in autonomous midwifery**. Midwifery that has enough time to give relational continuity of care does not have the problem of obstetric violence in the way that obstetric institutions do. By investing in autonomous midwifery, we **lessen the power of the obstetric institution** and our dependency on it. Also, it is an existing solution to the problem that keeps on being overlooked. In **most European countries**, **autonomous independent midwifery care still exists**, even when they are not supported by the state or the obstetric system. These **midwives already provide the respectful care** that we are fighting for when struggling against obstetric violence outside of the normal logistics and guidelines. The European Commission could, in setting up guidelines to prevent and decrease obstetric violence, strongly support and invest in the existence and proliferation of independent community midwifery-led care. Its focus must be on supporting and investing in existing care by autonomous midwives and make sure that they can practise safely and that their field can expand.

However, **to date almost all European countries have moved in the opposite direction** and true midwifery care, i.e. midwifery that has the freedom to work according to the midwifery philosophy of humane, individualised, relational continuity of care, has become more and more rare. Even in the Netherlands, the last country in Europe with a strong independent midwifery system, the government is moving towards the centralisation and dismantlement of the independence of midwives, rather than investing in small-scale community care. Our most important recommendation would hence be to advance the decentralisation of obstetric care into community midwifery-led maternity care that is supported and not dominated by obstetrics as much as possible.

Create awareness on multiple levels

However, **not all pregnant people are under midwife-led care**. The **majority of people gives birth in obstetrician-led care** (especially primipara). Therefore, it is important that efforts to prevent obstetric violence are initiated throughout maternity care systems, as well as to create awareness among all types of maternity care providers on the perspectives of pregnant people and their bodily autonomy and rights when receiving care in pregnancy and during childbirth. Furthermore, we must facilitate midwifery values, such as continuity of care and relationality, within obstetric settings. **Within the hospital, authoritative structures should be opposed and a safe and equal atmosphere between pregnant people, nurses, midwives and doctors must be facilitated. There must be attention to the workload and mental health of professionals working within the hospital**. Teams should be as small-scale, equal and respectful as possible. If we humanise working conditions, we humanise birth. Furthermore, the antenatal period must be used better to build relations of trust and in order to provide pregnant people with more information and exchange information on personal values and preferences.

Informed consent is an essential way of creating awareness about the problem of obstetric violence because it is inextricably related, thus provoking discussions and critical reflection. In medical settings, informed consent requires urgent attention, as negative experiences with care often includes situations in which acts are performed without informing pregnant people, or acts are performed even they have been refused.

Make sure a guideline on care outside of the normal guidelines is developed to ensure people's freedom to design their own care plan

One of the most successful initiatives to help victims of obstetric violence has been the guideline for working outside of care protocols. This has given people who have experienced obstetric violence the possibility to receive the care they need more easily. This can play an important role in tackling obstetric violence indirectly. We have seen that the existence of a guideline on care outside of guidelines has a positive effect on multiple levels. It gives professionals reassurance that it is in fact possible to go outside of guidelines and gives them clear steps on how to do it. This lessens their fear of malpractice related to their fear of punishment and disciplinary actions.[213] The guideline also validates pregnant people's request for such care and hence gives them back the autonomy to design their own care and get back some control, which is of the highest importance for victims of obstetric violence. Finally, an **official guideline on this matter provokes discussions about obstetric violence, informed consent and the value of guidelines in general. As such, it is a good way to discuss these topics within the maternity care system more broadly**.

213 van der Waal et al. (forthcoming b).

Address and tackle the problems of obstetric violence and obstetric racism at the same time

Another lesson from the Netherlands is that the **problems of obstetric violence and obstetric racism have recently been addressed as equally serious, connected problem**s in various trainings and working groups. In addition to obstetric violence, the Global North knows that another detrimental problem in obstetric care is obstetric racism. The issue of obstetric violence must be dealt with intersectionally, namely as always refracted through the problem of obstetric racism. **Maternal and neonatal mortality and morbidity of people of colour and refugees is significantly higher than that of white people in Europe in all countries with data. If we focus merely on solving the issue of obstetric violence**, we risk implementing reforms that will only be beneficial for people who are already receiving the best forms of care that we have to offer. Only when we deeply understand that violent structures such as classism, racism, misogyny and Islamophobia are intertwined within the obstetric institution, and all contribute to obstetric violence, we will be able to truly tackle the problem, rather than cover it up.

Teach all birth professionals extensively about obstetric violence and obstetric racism

Make sure that the topics of both obstetric violence and obstetric racism are an essential part of any professional training to work in the obstetric system. This is crucial for raising a new generation of more critical and self-reflective professionals, but also for the professionals who themselves struggle over the presence and their forced complicity with obstetric violence in their trainings. As long as we are sending students into a training field that we know is violent, we have an ethical obligation to teach them about obstetric violence and prepare them. **Students furthermore need a structure of confidential support to speak about, and professionally deal with, obstetric violence** they have encountered or were pressured to participate in during their internships.

4 SLOVAKIA by Barbora Holubová

4.1 Executive summary

Obstetric violence is a specific form of violence against women. Conducted by obstetric care providers on the body and reproductive processes of the woman, it is characterised by dehumanised assistance, abuse of interventionist actions, medicalisation and reversion of the process from natural to pathological.[214] The **recognition of women's suffering related to childbirth and reproductive and sexual health is,** however, **not straightforward** and requires targeted initiatives exposing this kind of violence. **In Slovakia,** the topic of obstetric violence has **appeared in two parallel streams**. One presents the **forced sterilisation of Roma women** and their long-term fight for justice from 2003 until now. The second stream relates to **violent practices during giving birth** and the continual recognition of obstetric violence as a systemic failure in the last decade.

The aim of the case study is to **present relevant manifestations, roots, prevalence and groups of women most affected by obstetric violence** in Slovakia based on available data. An additional aim is to describe the level of political and social recognition and effective measures that have been implemented in the country and which have raised awareness among the general public, the health sector and politicians. The report also presents measures with the potential to reduce the prevalence of obstetric violence.

Despite the **lack of an overall legal framework** for obstetric violence in Slovakia, non-governmental organisations (**NGOs**) have **used a human rights framework to address obstetric violence**. Slovakia is also a good example of the tremendous **importance of human rights organisations in countries where the control and enforcement authorities are not sufficient and have a lack of capacity** to address obstetric violence. The role of visual arts, for example, documentaries exposing obstetric violence, are a good practice to promote discussion and open ways for improvement.

The forced sterilisation of Roma women and their long-term struggle for justice point to the relevance of having a dedicated advocacy organisation who have knowledge of international legal mechanisms to appeal to where the national legal system fails.

Slovakia is also **a good example of how to raise awareness of obstetric violence through the implementation of independent monitoring** based on women's experiences with obstetric violence and by creating an independent network of obstetric violence experts. Gradual and continuous pressure from NGOs has resulted in the engagement of state human rights monitoring institutions on the topic. Pointing out the systematic violation of women's human rights during

214 Molla (2022).

childbirth has led to the first measures to prevent obstetric violence in Slovakia.

The main findings of this case study are as follows:

- **Visual artists and independent female filmmakers** have **contributed to increase public awareness** and bottom-up women's engagement in obstetric violence.
- While a **comprehensive definition of and legislation on obstetric violence are missing** in Slovakia, some forms and aspects of obstetric violence are protected or sanctioned within selected acts.
- Slovakia **lacks** valid population-based **prevalence data on obstetric violence**. Quantitative data on the prevalence of obstetric violence is available in a non-systemic way and based on non-randomised samples.
- Numerous **testimonies of affected women** have **revealed the multiple manifestations** of obstetric violence, either in prenatal or postnatal care or during giving birth.
- Several **studies have revealed the level of discrimination in obstetric care services, the forced and violent sterilisation of Roma women**, and physical and verbal attacks and racial discrimination in the provision of healthcare. Roma women receive insults from doctors and nurses and are beaten, attacked, humiliated and neglected.
- **Forced surgical sterilisation and forced castration are related to people undergoing gender transition.** Transgender people are a hard-hit group due to violations of their sexual rights, including forced surgical sterilisation due to Christian ideology and gendered stereotypes.
- **Slovakia** is among the European countries with **the highest number of caesarean sections and episiotomy** is a routine procedure often without medical indication.
- The **root causes of obstetric violence are structural gender-based discrimination, sexism and power imbalance.** The objectification of women and patients in the health system results in inhuman care provision.
- **Racism against the Roma population translates to a discriminatory approach** to Roma women in obstetrics.
- The setting of **obstetrics health systems is based on the patriarchal and hierarchal relations** between obstetricians and midwives.
- The **Covid-19 pandemic has had a significant impact on childbirth** since 2020. It has shown that even slow progress can be stopped or reversed.
- The long history of **forced sterilisation illustrates the slow and gradual recognition of obstetric violence** in Slovakia.
- **The Ministry of Health** of the Slovak Republic is **implementing two standard procedures to unify and improve the provision of healthcare during pregnancy and childbirth, which could prevent obstetric violence** in the future.

4.2 Introduction

The topic of obstetric violence appeared in Slovakia in two parallel streams. The first stream presented cases of forced sterilisation of Roma women during communism before the political change in 1989, which led to a change in legislation, a judgment of the EU Court of Human Rights and an official apology from the Slovak Republic. The second stream renders the disproportionate and violent practices during the births, exposed by female filmmakers and women's NGOs since 2016. The activities led to partial improvements; however, they are in the shadow of harmful or disrespectful obstetric practices. Both streams converge and frame obstetric violence as a violation of women's human rights, discrimination and a violation of the right to adequate healthcare.

An important characteristic of the development of the topic in Slovakia is the **gradual expansion of actors and stakeholders involved in monitoring and advocacy** for the elimination of obstetric violence. Although at the beginning of the development of the topic, NGOs were exclusively involved, gradually the topic was adopted by public institutes for the protection of human rights. Later, international organisations also expressed support and demanded corrections.

Another inherent feature of the Slovak case is **the role of visual art in initiating the public discussion** on obstetric violence. Documentaries created by independent female filmmakers and seen by thousands in Slovakia pictured how babies were born in maternity hospitals, how doctors dealt uncooperative mothers with a slap, how the medical staff treated women without respect, dignity and privacy and how the women left the maternity wards with trauma. The documentaries contributed significantly to the state of obstetrics in Slovakia beginning to be discussed throughout society. It was no longer just a topic of women on internet forums or women's rights activists but a problem concerning children themselves, families and health professionals.

The forced sterilisation of Roma women and their long-term struggle for justice point to the **relevance of having a dedicated advocacy organisation who have knowledge of international legal mechanisms** to appeal to where the national legal system fails.

Slovakia is also a good example of the **process of how to raise awareness of obstetric violence** using the following strategies:

- Implementation of independent monitoring of women's experiences with obstetric violence
- Creation of a network of obstetric violence experts
- Engaging state human rights monitoring institutions
- Pointing out the systematic violation of women's human rights during childbirth
- Creating consistent and gradual pressure on the responsible state institutions for correction.

4.3 Definitions and references

While a comprehensive definition of and legislation on obstetric violence are missing in Slovakia, some **forms and aspects of obstetric violence are protected or sanctioned within selected acts.** Particular crimes of obstetric violence and obligations to follow specific principles in order to prevent obstetric violence are encompassed in the Criminal Code and Healthcare Act by the following articles:

- Criminal Code Act. No. 300/2005 Coll.[215]
  - » §159 (1) Whoever unlawfully removes an organ, tissue or cell from a living person, or who unlawfully procures such an organ, tissue or cell for himself or another, shall be punished by imprisonment for two to eight years.
  - » §159 (2) As in paragraph 1, whoever sterilises a natural person without authorisation shall be punished.
  - » §158 Whoever negligently injures the health of another by violating an important duty resulting from his employment, profession, position or function or imposed on him/her by law.
  - » §157 Anyone who negligently injures the health of another by violating an important duty resulting from his employment, profession, position or function or imposed on him by law shall be punished by imprisonment for up to one year.
- Act No. 576/2004 Coll. on healthcare, services related to the provision of healthcare and on amendments to certain laws as amended by Act no. 41/2013.
  - » §40 (2) Sterilisation can only be performed based on a written request and written informed consent after prior instruction of a person fully capable of legal acts or the legal representative of a person incapable of giving informed consent or based on a court decision based on the request of a legal representative.[216]
- Act No. 576/2004 Coll. on healthcare, services related to the provision of healthcare and on amendments to certain laws as amended by Act no. 41/2013.
  - » §11 (9) Rights and obligations of persons in the provision of healthcare; When providing healthcare, everyone has the right under the conditions established by this law to:
    a) Protection of dignity, respect for one's physical integrity and psychological integrity,
    b) Information regarding his state of health,
    c) Information about the purpose, nature, consequences and risks of the provision of healthcare, about the options for choosing the proposed procedures and the risks of refusing the provision of healthcare (§ 6 paragraph 1),
    d) Refusal to provide healthcare, except for cases in which, according to this law, healthcare can be provided without informed consent (§ 6, paragraph 9),
    e) Decision on their participation in teaching or biomedical research,

215 https://www.zakonypreludi.sk/zz/2005-300.

216 https://www.zakonypreludi.sk/zz/2004-576#p40.

f) Maintaining the confidentiality of all data related to his health condition, facts related to his health condition, if in the cases established by a special regulation) the healthcare worker is not exempted from this confidentiality,
g) Alleviation of suffering,
h) Humane, ethical and dignified approach of healthcare workers.[217]

Additionally, the **international human rights framework** is applicable, in particular:

- The right to human dignity
- The right to the protection of health and the right to healthcare
- The right to information and informed consent
- The right to the protection of private and family life
- The right to equality and non-discrimination
- The right not to be subject to violence, torture and other cruel, inhuman and degrading treatment.

The following **international conventions can be applied to obstetric violence**:

- Convention on the Elimination of All Forms of Discrimination against Women
- International Covenant on Economic, Social and Cultural Rights
- International Covenant on Civil and Political Rights,
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Convention on the Rights of Persons with Disabilities
- Convention on the Elimination of All Forms of Racial Discrimination
- Convention on the Rights of the Child.

Relevant conventions adopted by the Council of Europe are the Convention for the Protection of Human Rights and Fundamental Freedoms, the Convention on Human Rights and Biomedicine, and the European Social Charter (revised).

217 https://www.zakonypreludi.sk/zz/2004-576#p9.

4.4 Data collection and evidence on obstetric violence in Slovakia

4.4.1 Empirical evidence (quantitative and qualitative)

In 2003, based on 230 interviews conducted with Roma women from marginalised communities throughout Eastern Slovakia, a study found that most of the women appeared to have been sterilised without prior and informed consent. The study revealed **testimonials of numerous cases of forced and violent sterilisation of Roma women, physical and verbal attacks, racial discrimination in the provision of healthcare**, misinformation of these women on health issues and denial of access to health documentation.[218]

Another study was based on interviews with more than 140 Roma women who were forced or forcibly sterilised or had reasonable suspicion that they were forcibly sterilised. Approximately 110 of these interviews were conducted with women who were sterilised or strongly suspected of having been sterilised after the fall of Communism. About 30 interviews remaining in this category were with women who were sterilised during the Communist regime as part of the practice of providing financial motivation for undergoing sterilisation.[219]

Forced sterilisation and forced castration relate to people undergoing gender transition. To date, Slovakia was one of the last European countries that required transgender people to undergo mandatory castration (removal of reproductive organs) when legally changing their gender (and therefore changing their name and birth number). At the same time, there is no legal regulation of the gender transition process. Slovak transgender people and LGBTI+ organisations have been trying to change this situation for over a decade.

Population-based quantitative data on the prevalence of obstetric violence is available in a non-systemic way and based on non-randomised samples. One such survey from 2021 refers to an online inquiry conducted by the NGO Citizen, Democracy and Accountability. Women disclosed various manifestations of obstetric violence, such as the refusal of the presence of an accompanying person during birth (61 out of 87 women), lack of consent to medical interventions (15 out of 59) and the course of the labour delivery entirely determined by the hospital staff (48 out of 86 women). A relatively high number of women experienced other painful procedures during their labour or delivery. For example, 56 women (out of 94) experienced labour induction, 35 (out of 95) experienced episiotomy and 31 women (out of 95) underwent the Kristeller manoeuvre, which is not recommended by WHO and is prohibited in Slovak hospitals.[220]

A 2020 online survey found in the sample of 3 164 women who gave birth that 48 % experienced episiotomy (28 % were not informed and did not consent to the intervention). In the survey, 23.92 % of respondents said that stitching maternity injuries was an excruciating procedure. In 14.53 % of cases, the reason for it being painful was they did not receive anaesthesia.[221]

The prevalence of some forms of obstetric violence might be indicated by the administrative health data on incidents of medical procedures which are either prohibited or not recommended by WHO. In 2020, complications during and after childbirth concerned 16 795 women giving birth (29.9 % of the total number of

218 Center for Reproductive Rights and Center for Civil and Human Rights (2003).

219 Center for Reproductive Rights and Center for Civil and Human Rights (2003).

220 Debrecéniová (2021).

221 Thominet (2021).

women giving birth). The most common cases were incisions of the perineum (episiotomy) (9 864 women in labour) and tearing (rupture) of the perineum (6 261 women in labour).[222]

Episiotomy is the most prevalent complication that women in childbirth experience, presenting from 13 % to 17 % of all complications. The number of episiotomies provided increased from 2018 to 2020, each year, even though the women reported the harm, pain and trauma that resulted from the procedure (see table below).[223] Independent experts also pointed to the often unnecessary episiotomy provided without local anaesthesia.

The second most prevalent harmful medical procedure connected to obstetric violence is tearing (rupture) of the perineum, from 7 % to 11 % of all complications. The number of these procedures also increased in the last three years (see Table below).[224]

Table 2: Women giving birth with complications during childbirth

Complication during or after childbirth	Total		
	2020	2019	2018
Number of women giving birth	56 238	56 596	57 059
Number of women giving birth with complications	16 795	15 938	12 131
Uterine rupture	48	67	67
Hysterectomy < 48 hours	52	53	52
Placental retention	379	414	381
Eclampsia ≤ 14 days	17	10	16
Blood loss > 1 500 ml	74	113	89
Shoulder dystocia	213	225	234
Sepsis	11	18	19
Episiotomy	9 864	9 472	7 313
Embolism	31	24	21
Tearing (rupture) of the perineum	6 261	5 676	4 054
Other	1 648	1 670	1 250
per 100 women giving birth			
% of women giving birth with complications	29.9	28.2	21.3
Uterine rupture	0.1	0.1	0.1
Hysterectomy < 48 hours	0.1	0.1	0.1
Placental retention	0.7	0.7	0.7
Eclampsia ≤ 14 days	0.0	0	0.0
Blood loss > 1.500 ml	0.1	0.2	0.2
Shoulder dystocia	0.4	0.4	0.4
Sepsis	0.0	0	0.0
Episiotomy	17.5	16.7	12.8
Embolism	0.1	0	0.0
Tearing (rupture) of the perineum	11.1	10	7.1
Other	2.9	3	2.2

Source: NCZI-National Centre of Health Information, 2022.

222 NCZI (2020).

223 NCZI (2018–2020).

224 NCZI (2018–2020).

Another indication of inadequate health services provision is indicated by the number of surgical births. **Slovakia is among the European countries with the highest number of caesarean sections**. The number of caesarean sections nearly doubled from 2004–2020 and are some 30 % of all births. Of the 16 658 caesarean deliveries in 2020, 57.1 % (9 517) of interventions were indicated before delivery, 22.3 % (3 711) resulted from an acute situation during delivery, and 20.6 % (3 430) from an acute situation before delivery (see table below).[225]
In 2020, of the total number of 56 238 births, 67.6 % (38 043 births) were spontaneous and the remaining 32.4 % (18 195) were surgical births.
Due to operative delivery, the most frequently chosen procedure was caesarean section (91.6 %; 16 658 births). According to the National Centre of Health Information, in other cases, it was necessary to finish the birth process with the help of a bell (vacuum extractor) (7.1 %; 1 288 births); rarely was the surgical method chosen during birth forceps (1.3 %; 233 births) or extraction (0.1 %; 16 births). The statistics show that the older the mother is, the higher the probability of giving birth by surgical method (see table below).[226]

Table 3: Development of the number of births by the method of birth (2004–2020)

Method of birth	Year										
	2004	2006	2008	2010	2012	2014	2016	2017	2018	2019	2020
Total	51 968	51 094	53 457	55 012	54 975	54 584	57 027	57 452	57 059	56 596	56 238
Spontaneous	40 638	38 511	38 715	37 699	36 593	36 104	38 150	38 283	38 692	38 405	38 043
Surgical	10 765	12 222	14 376	16 874	17 982	18 054	18 432	18 681	18 367	18 191	18 195
Within which:											
Caesarean section	9 896	11 267	13 349	15 765	16 863	16 912	17 122	17 215	16 882	16 741	16 658
Forceps	284	365	384	337	338	328	311	334	308	224	233
Vacuum extractor	585	590	643	772	781	814	999	1 132	1 122	1 214	1 288
Extraction	.	.	.	.	.	.	.	.	55	12	16
Pelvic end	148	282	297	265	224	227	249	241	.	.	.
Expression	–	79	68	174	176	199	196	247	.	.	.
Other	381	–	–	–	–	–	–	–	–	–	–
Unknown/ unspecified	36	–	1	–	–	–	–	–	–	–	–
Percentage											
Total	100	100	100	100	100	100	100	100	100	100	100
Spontaneous	78.2	75.4	72.4	68.5	66.6	66.1	66.9	66.6	67.8	67.9	67.6
Caesarean section	19.0	22.1	25.0	28.7	30.7	31.0	30.0	30.0	29.6	29.6	29.6
Forceps	0.5	0.7	0.7	0.6	0.6	0.6	0.5	0.6	0.5	0.4	0.4
Vacuum extractor	1.1	1.2	1.2	1.4	1.4	1.5	1.8	2.0	2.0	2.1	2.3
Extraction	.	.	.	.	.	.	.	.	0.1	0.0	0.0
Pelvic end	0.3	0.6	0.6	0.5	0.4	0.4	0.4	0.4	.	.	.
Expression	–	0.2	0.1	0.3	0.3	0.4	0.3	0.4	.	.	.
Other	0.7	–	–	–	–	–	–	–	–	–	–
Unknown/ unspecified	0.1	–	0.0	–	–	–	–	–	–	–	–

Source: NCZI-National Centre of Health Information, 2022.

225 NCZI (2020).
226 NCZI (2020).

Administrative data on the **crimes of illegal sterilisation** is collected if the offence is **registered and investigated by the police. Since 2017, no such crime has been reported**.

In-depth interviews with 38 Roma women living in eastern Slovakia explored their experiences in reproductive and maternal healthcare settings. Almost all the women interviewed said they had been subjected to disrespectful treatment and abuse by medical personnel in gynaecology offices or hospital maternity departments. Their accounts described various forms of conduct that they found disrespectful, ranging from raised voices and shouting to degrading and offensive forms of address and conduct to vulgar verbal abuse, including racial slurs and physical abuse. Some of the women also described feeling neglected during labour and childbirth and that they were treated only after non-Roma patients. They also said that they were not fully and adequately informed about their medical treatment. Some women also gave accounts of physical abuse by medical professionals. Most of the women interviewed explained that they felt upset and humiliated at being placed in separate 'Roma only rooms' on top of other segregation.[227]

4.4.2 Relevant manifestations

A **broad monitoring of the current state of affairs** in Slovak birthing facilities was **conducted in 2015** and revealed several forms of obstetric violence.[228] One of the forms of **violent and rough treatment** was not allowing women to freely choose the position (during the first and second stages of labour) that would suit them and which would bring them relief from their pain. Women were thus forced during the first and second stages to stay in an uncomfortable, unpleasant and painful lying position the research interviews also recorded the tying of the legs in stirrups during the second stage).

Another form of violation of the right to provide maternity care without violence was the implementation of the so-called Kristeller expression, i.e. pressure on the fundus. This practice was extremely painful for women, according to women's descriptions, performed routinely and without prior communication and often without their consent. It can be considered a form of violence and cruel and inhumane treatment.[229] In some cases, the episiotomy was performed without consent or consciousness of the woman giving birth and a painful stitching of birth injuries, which is also a violation of the right to birth care without violence, torture and cruel, inhuman and degrading treatment.[230]

A **subsequent monitoring of the state of obstetrics in 2016** revealed further **serious violations of the human rights of women** in connection with the provision of obstetric care in Slovakia, violations which seemed to be systemic.[231] The violations involved **all human rights affected during births and were inflicted by individual healthcare professionals, healthcare facilities and the State**:

- Interventions and **practices** applied were often in **conflict with internationally recognised** medical **guidelines**.

227 Centre for Reproductive Rights & Centre for Civil and Human Rights (2017).

228 Babiaková et al. (2015).

229 Babiaková et al. (2015).

230 Babiaková et al. (2015).

231 Debrecéniová (2016).

- The **treatment of women giving birth** often included **elements** of physical or psychological **violence**.
- The **right to information** was **violated** throughout the entire birthing process.
- There were considerable **differences between medical guidelines generally accepted at the international level and the common practices** applied by many Slovak healthcare facilities.[232]

Additional manifestations of obstetrics violence observed in Slovakia were:

- **Women** did **not have enough intimacy and privacy during childbirth**; they lay in overcrowded rooms, gave birth in birthing boxes that were insufficiently separated from each other or had chairs turned inappropriately towards the door during childbirth.[233]
- **Episiotomy is performed on almost every one** out of two women giving birth, while in many cases it is done routinely and without a medical reason. These women cannot find effective help and a satisfactory solution to their problems (Women's Circles).
- There is **no network of health services** in Slovakia **for women who have problems with wound healing after childbirth**, experience **difficulties with breastfeeding** or **need mental healthcare**. Such help is unavailable for a large group of women.
- **Awareness** is **insufficient** about the possibilities of **prevention and support in the area** of mental health of women giving birth.[234]

The discrimination faced by Roma women in obstetric care services and care in maternity hospitals and in gynaecological departments of many hospitals in Eastern Slovakia deserves particular mention, revealing elements of systematic and blatant racial discrimination, including segregation. Roma women are separated from white women and are placed in different rooms than white women. Roma women are often prevented from using the same bathrooms, toilets and eating facilities as white women. Their requests to be transferred to integrated rooms are ignored.[235]

Roma women encounter insults from doctors and nurses. Roma women also receive lower-quality treatment or are refused treatment altogether. Some doctors have limited hours for Roma women or Roma women are forced to wait for emergency treatment until they investigate the white women first. Ambulances from certain hospitals in Eastern Slovakia either refuse or hesitate to provide services to pregnant women in Roma settlements, even when the woman is already giving birth. Corruption among medical staff is endemic: all women are required to pay for services that are covered by health insurance, or they are provided with low-quality treatment if the health professionals feel that the bribe is not sufficient. However, Roma women, who are often discriminated against because of racial intolerance and who, perhaps because of their lower economic status cannot afford to pay bribes, feel this corruption even more acutely.[236]

232 Debrecéniová (2016).

233 Thominet (2021).

234 Žureková (2022).

235 Center for Reproductive Rights and Center for Civil and Human Rights (2003).

236 Centre for Reproductive Rights 2023).

Interviews with Roma women who use maternity health services in hospitals in Eastern Slovakia revealed devastating clashes with doctors and nurses. **Roma female patients are beaten, attacked, humiliated and neglected.** Hospital directors, doctors and nurses openly express racist views about female Roma patients, whom they consider morally questionable, unable to provide for their children and who do not deserve healthcare. Many healthcare workers complain about the high number of Roma children and consider their high birth rate as a direct threat to Slovakia. These biased attitudes influence the behaviour of medical personnel towards Roma patients who suffer from the consequences of poor reproductive healthcare and are otherwise marginalised, resulting in a negative impact on the overall health status of Roma women.[237]

Roma women interviewed in 2017 reported experiencing ongoing segregation in maternity care departments, racial harassment and humiliation, neglect, physical restraint and abuse during childbirth and failures related to informed consent and decision-making concerning medical treatment. All of these issues point to violations of Slovakia's human rights obligations under international and domestic law and reveal an urgent need for the state to adopt effective and comprehensive measures to guarantee Roma women's human rights and improve the quality of reproductive and maternal healthcare in Slovakia.[238]

4.5 Root causes of obstetric violence

Obstetric care in Slovakia is monopolised and institutionalised, concentrated almost exclusively in healthcare facilities. This, combined with women being particularly vulnerable during pregnancy and birth, makes **obstetric care a specific phenomenon demonstrating a power imbalance**.[239] One of the root causes of obstetric violence is the **objectification of women and patients in the health system**. Women are often not approached as persons but as objects of medical intervention. Objectification can be 'we know what is best for you and you do not need to know it'. Women are often not granted subjectivity in childbirth. Women's specific ideas of how they would like to give birth are perceived as interfering with the competence of obstetricians and threatening their professional honour. The overall racism **against the Roma population** translates into discrimination against Roma women from segregated communities in gynaecology and obstetrics.

Condescending behaviour and a gendered power dynamic contribute to strongly disrespectful behaviour from healthcare providers to women, the denial of women's autonomy, and pushing women into the role of passive receivers of ideas, requirements and procedures by medical personnel. The hierarchy of the medical system with women patients and clients and individual persons at a lower rank than medical personnel puts symbolic and real power into the hands of medical personnel in situations where women are extremely vulnerable and depend on them.[240]

The overall setting of the obstetrics health system is based on **patriarchal and hierarchal relations between obstetricians and midwives.** Several studies show that if low-risk mothers are cared for by midwives, they have a lower risk of

237 Center for Reproductive Rights and Center for Civil and Human Rights (2003).

238 Centre for Reproductive Rights & Centre for Civil and Human Rights (2017).

239 Babiaková et al. (2015).

240 Babiaková et al. (2015).

complications, interventions in childbirth or even caesarean sections.[241] In some maternity hospitals, midwives are accepted and can fulfil their competencies in practice – caring for low-risk women giving birth and assistance during the birth. However, the situation is at a standstill in most maternity hospitals and the traditional concept of medically led birth persists. In this respect, improvement in the position of midwives in the care system for women in giving birth is minimal.[242] Since the number of gynaecological-obstetric medical personnel is decreasing yearly, it is likely that the role of midwives will become increasingly necessary for low-risk mothers. But there are currently only around 1 600 midwives in Slovakia and ideally, there should be one for every woman giving birth.[243]

The abuse of the doctrine of medical necessity and the risk approach contributes to the limited number of home births and the stigmatisation of giving birth in other than a medical institution. In Slovakia, it is not legally forbidden for a woman to give birth at home. It is not even legally established that a woman should give birth only in a medical institution of institutional healthcare. However, from the provisions of § 4 par. 3 of the Decree of the Ministry of Health of the Slovak Republic no. 364/2005, it follows that the midwife is entitled to perform defined actions (including physiological childbirth) independently, but in a healthcare facility. Thus, the law does not explicitly prohibit home birth but does not provide for it either: the midwife would act contrary to *lege artis*, the approved way of practising, and putting herself at risk of disciplinary or criminal prosecution.[244]

4.6 Consequences of obstetric violence

Maternal mortality results from severe obstetric complications and conditions which mostly do not lead to death. Maternal morbidity is not adequately measured, however, because there is no international agreement about the definition of the conditions and also because the recording of these conditions is not standardised in routine hospital discharge databases, the primary source of this data.[245] Maternal death is defined as the death of a woman while pregnant or within 42 days of the termination of pregnancy, regardless of the duration and site of the pregnancy, for any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. The maternal mortality rate is thus the number of all maternal deaths from direct and indirect obstetric causes per 100 000 live births. Because the number of deaths yearly is so low in most countries, data is used covering five years (2011 to 2015). Slovakia reports a rate below 5 per 100 000 births in 2011–2015; however, the number might be underestimated.[246] The total **death rate (mortality) of newborns** between 2017 and 2020 rose slightly from 4.43 per thousand to 5.5 per thousand.[247]

241 Souter et al. (2019).
242 Žureková (2022).
243 Žureková (2022).
244 Grejtáková (2016).
245 European Perinatal Health Report (2015).
246 European Perinatal Health Report (2015).
247 Žureková (2022).

4.7 Obstetric violence and Covid-19

The Covid-19 pandemic has had a major impact on childbirth since 2020. It has shown that even progress that is slow can be stopped or reversed. In practice, care for women has deteriorated significantly in many ways. For example, **premature babies were separated from their parents, who did not see them for weeks**. Similar cases also occurred with healthy children and their mothers infected with the coronavirus.[248]

At the time, the recommendations of international obstetric organisations, including the Slovak guidelines issued by the chief expert for gynaecology and obstetrics, were based on the fact that if a woman is capable of caring for a child, it is inappropriate to separate them and thus prevent breastfeeding. Despite that, **NGOs and doulas observed an increase during the pandemic of violations of women's rights.** For example:

- Women were not provided with adequate post-partum care. They were often either sent home prematurely or were hospitalised in Covid wards without adequate post-partum care.
- Some hospitals impose a ban or set impossible conditions for the presence of a partner during childbirth, such being present in the delivery room only for 15 minutes.
- At the beginning of the pandemic, the vast majority of maternity hospitals interfered with women's rights in a significant way.[249]

A long-term doula, who accompanies women during childbirth and has experience in many maternity hospitals, described a harmful situation at that time:

> *'I dealt with one woman who, when she wanted to leave the maternity ward on the second day after giving birth, the staff locked the door of the delivery ward so that she could not leave. It was solved only by the arrival of the police, who were called by the woman's husband – a lawyer. After a conversation between the police and the staff, the woman was released home.'*[250]

The NGO Citizen, Democracy and Accountability monitored complaints about the violation of healthcare provision and human rights related to prenatal, obstetric and postnatal care. The reference period of the monitoring was during the Covid-19 pandemic from **March 2020 to March 2021**. The findings indicate that **most of the complaints were assessed as irrelevant** and justifiable by the control bodies. Only a few **complaints** were **investigated** by the supervisory agencies, mostly **labelled as 'improper provision of healthcare' or 'deficient medical records'**. The remedy was based on 'instruction of the responsible worker' or a fine of EUR 400. In general, the monitoring found that an effective mechanism of control and remedies is missing in Slovakia and that the control bodies cover up violations of women's rights in prenatal, obstetric and postnatal care.[251]

248 Žureková (2022).
249 Žureková (2022).
250 Žureková (2022).
251 Debrecéniová (2021a).

4.8 Achievements and challenges in collecting and monitoring data

Systemic monitoring or data collection of obstetric violence is not established in Slovakia. Nor has an official observatory covering obstetric violence been established in Slovakia. However, **several NGOs have been mapping obstetric violence using a human rights approach for several years within specific projects**, usually funded by an independent foundation, such as the Open Society Foundations. A survey on obstetric violence commissioned by the Office of **the Public Defender of Rights was released in 2021**. However, this was a one-time, non-recurring activity. Moreover, the Public Rights Defender newly elected in November 2022 will probably have other priorities as he was assigned by the prevalently conservative national council.

4.9 Relevant initiatives and their impact

4.9.1 Initiatives leading to political action

Relevance of the topic in political and institutional debate

The debate and case of **forced sterilisation** of Roma women resonated with the public, due to the long-term campaign of and pressure from the NGO Centre for Reproductive Rights and the Centre for Civil and Human Rights. However, **the long history of this issue illustrates the slow and gradual recognition of obstetric violence in Slovakia.**

In 2003, a study made up of 230 interviews conducted with Roma women from marginalised communities throughout Eastern Slovakia found that most of the women appeared to have been sterilised without prior and informed consent.[252] The case sparked discussion in Slovakia on the importance of ensuring patients' informed consent before sterilisation or other medical procedures are performed.

As a result, in 2004 new legislation was adopted introducing informed consent procedures, including a specific provision on informed consent before sterilisation and expanded protections for patients seeking access to their medical records. Despite these legal reforms, Slovak authorities have failed to take meaningful steps to investigate past instances of forced and coercive sterilisation and ensure that survivors are provided with effective remedies and reparations. Although the allegations of unlawful sterilisation elicited responses from both the Ministry of Health and law enforcement authorities and although criminal investigations were opened, these investigations had numerous flaws and were ineffective.[253]

Between 2011 and 2013, the European Court of Human Rights (ECHR) upheld women's claims and found violations of the European Convention in three separate cases brought by Roma women. It dismissed state assertions that the sterilisations were necessary for 'health reasons,' reasoning instead that because sterilisation is not a life-saving medical intervention, informed consent is always needed before the operation is performed. According to the ECHR, the women in these cases were treated in a manner that was paternalistic and incompatible with the principles of respect for human freedom and dignity because they were deprived of the chance to freely decide whether or not to be sterilised. The Court, therefore, found violations of their rights to freedom from inhuman and degrad-

252 Center for Reproductive Rights and Center for Civil and Human Rights (2003).

253 Centre for Reproductive Rights & Centre for Civil and Human Rights (2017).

ing treatment and respect for their private lives and granted each applicant financial compensation between EUR 25 000 and EUR 31 000.[254]

In 2016, after a lengthy proceeding of 11 years, a Slovak court awarded a Roma woman who had been sterilised in 1999 without her informed consent compensation for the total amount requested (EUR 16 597). The hospital was also ordered to apologise to her formally. Following the reasoning and approach of the ECHR, the court ultimately found that the woman's right to personal integrity had been violated.[255]

In November 2021, the Government of the Slovak Republic adopted the 'Apology for sterilisations in violation of the law', the purpose of which was primarily to express regret in cases that have a solid human rights dimension and to apologise for sterilisations in violation of the law, which were implemented in Slovakia in the years 1966–1989 and 1990–2004.

Degree of recognition of the topic by healthcare providers; effective measures implemented

In 2021, the Ministry of Health of the Slovak Republic implemented two **standards and procedures to unify and improve the provision of healthcare during pregnancy and childbirth**. The Ministry of Health expects the introduction of the mentioned standard procedures to increase the acceptance of the latest scientific knowledge in everyday obstetric practice with full respect for women's rights in the provision of health services.[256] However, the NGOs working in this area point to insufficient and ambiguously formulated measures for preventing obstetric violence against women in the standards.[257]

The goal of the first standard procedure, called 'Prenatal care for low-risk pregnancy', is a uniform procedure in pregnancy monitoring, prevention and early detection of deviations indicating the possible emergence of maternal complications. The intention of the standard is also early detection of deviations in the prenatal development of the foetus and proper preparation for childbirth. The goal of the second standard procedure, entitled 'Care of a low-risk mother during childbirth' is a uniform procedure during monitoring and assistance during childbirth for low-risk mothers.[258]

Some of the measures in the standards procedures also relate to preventing obstetric violence, for example, rules regarding the accompanying person, informed consent, the right to privacy and performing an episiotomy, i.e. cutting the perineum. According to the new standards, routine episiotomy is not recommended for spontaneous vaginal birth. Each workplace should now regularly audit episiotomies and other injuries to the perineum during childbirth. The standards also point out that all operations, including episiotomy, require the informed consent of the mother. The previous monitoring found that the medical staff often equated informed consent only 'with the mother's automatic signature.' However, the new standards introduce the requirement that all actions performed on the mother require her informed consent, which can be either verbal or declarative, for example, the mother nods or makes a move to enable the

254 Centre for Reproductive Rights & Centre for Civil and Human Rights (2017).

255 Centre for Reproductive Rights & Centre for Civil and Human Rights (2017).

256 Ministry of Health (2021, 2021a).

257 Žureková (2022).

258 Ministry of Health (2021, 2021a).

action. Furthermore, the standards state that other medical procedures require oral informed consent.[259] Finally, the standards give the mother the right to the presence of an accompanying person or persons during the entire birth process. However, their number is limited by the possibilities of the workplace.

Degree of recognition of the topic by the general public and women

Visual artists and independent female filmmakers contributed to raise public awareness and bottom-up women's engagement on obstetric violence.

The topic of harassment and trauma from childbirth has been discussed in online space and various social media platforms by women sharing their hospital experiences since 2010. However, it was a documentary film that significantly raised the topic of obstetric violence. The documentary, **'Medzi nami' (Before I met you,[260] directed by Zuzana Limová** chronicles **women's efforts to maintain their dignity through childbirth** and offers their testimonies. After the Slovak premiere of the film, a passionate societal discussion about obstetrics broke out. Women's experiences suddenly made it into the evening news and the headlines of important newspapers. The documentary chronicles women's efforts to maintain their dignity through childbirth and offers the testimonies of those who found the courage to speak out. The testimonies are supplemented by images captured during weekdays in the state maternity hospital and interviews with the staff. It was filmed on the premises of the University Hospital in Bratislava with an international team, but threats from the hospital blocked it for several months. The documentary intensified the topic of human rights by childbirth and is used to date as training material in public discussions for various types of audiences.

The second relevant initiative which contributed to further awareness-raising about obstetric violence was the **documentary, 'Neviditeľná' [Unseen], by director Maia Martiniak in 2020**.[261] The documentary **sparked discussion and intensive media coverage**. The documentary **captures women's stories**, which open up the controversial and socially rejected topic of birth trauma. Complemented by real births, the theme of trauma is investigated, showing a hidden reality in society and making visible women who until now have been silenced by the pressure of the environment or medical staff. The documentary in a sensitive way opens up the need for change not only in Slovakia but also in the world. After the documentary showed that women leave the maternity hospital traumatised, the recognition of the need to humanise Slovak obstetrics deepened even more. Civil associations, the public defender of rights and the midwives themselves began to point out the shortcomings of the system more often.

The visual arts also contributed to recognising **the structural racism in obstetrics** that **Roma women face** in Slovakia. The Centre of Civil and Human Rights in cooperation with Roma male and female activists prepared a series of videos in 2021. The campaign, 'Challenging barriers in access to justice through sharing stories of Roma women', stressed why it is importance to stand up for human rights and highlighted the services of the Centre. Roma women shared their messages in the videos. The joint effort was to inspire other people to ac-

259 Ministry of Health (2021, 2021a).

260 Trailer: https://www.youtube.com/watch?v=iiEfB2sghVY.

261 Trailer: https://www.youtube.com/watch?v=Du3z-THFNh4; Media coverage: https://unseen.film/press-festivals/; Discussion on the film at the Festival 'One World' https://www.facebook.com/watch/?v=2083846875072520.

tively defend their rights. One of the videos features the story of Mrs Jana – one of the Romani women who was forcibly sterilised by doctors in the past.[262]

4.9.2 Initiatives to combat obstetric violence

Relevant initiatives to address the topic

On 1 January **2019**, the **Ministry of Health** approved the so-called **standard procedures for prevention of obstetric violence** titled, *Mother and newborn care according to the principles of the Baby-friendly Hospital Initiative (BFHI)*.[263] It **defines the principles of care for the mother and child** in the period before, during and after birth in medical facilities with the aim to support bonding and breastfeeding as much as possible. According to the Ministry, **the tool**, which they **created according to WHO recommendations**, was created **in response to information about the disrespectful treatment of women** in connection with **childbirt**h, which was brought to the attention of the third sector and the public defender of rights. Using the procedures, **more than 200 gynaecologists-obstetricians, paediatricians, neonatologists, midwives and nurses** from all hospitals in Slovakia **were educated** about the positive approach to women and newborns. In Eastern Slovakia, education was also focused on the specific and cultural needs of the Roma population.

The Ministry of Health has also created **tools for systematically checking compliance with these procedures**, i.e. a clinical audit that evaluates the application of standards in practice. They were mainly **implemented before the pandemic's start, but they have stopped since 2020**. The reason is the **lack of funds** and **professional staff** to carry out the audits. Following the start of the pandemic, compliance is monitored through internal assessments. Currently, however, there is not a single hospital in Slovakia that has a BFHI certificate.[264]

Relevant initiatives to involve and train health professionals in recognising, understanding and preventing obstetric violence

The initiatives involving the **training of health professionals targeting the mistreatment of women giving birth and some aspects of obstetric violence** have been **organised more often by NGOs** than state institutions. Nevertheless, some of the courses at the medical universities indicate that the issues of **obstetric violence might be perceived** prevalently as **communication or ethical issues** and not as a violation of human rights or respective regulations, or even as a crime.

Let's talk about women's human rights by childbirth[265] is a series of **workshops provided by the NGOs Citizen, Democracy and Accountability and Women's Circles** in 2018. The courses targeted professional midwives from hospitals and community midwives and lactation consultants. The aim was to promote discussion and provide education in the field of women's rights in childbirth, thereby promoting equal, respectful and effective cooperation of all those involved in childbirth. Education and increasing understanding of human rights – e.g. the right to privacy, information, dignity and respectful treatment – are nec-

262 https://poradna-prava.sk/en/videos/.

263 Ministry of Health (2020).

264 Žureková (2022).

265 http://odz.sk/vydarene-podujatie-workshop/.

essary to eliminate violations of women's rights during childbirth. The workshop strengthened all the actors present and created space for cooperation and their long-term involvement in the human rights activities of the NGOs.

Strengthening communication skills of midwives [266] was **a training organised by the NGO Women's Circles in cooperation with the Slovak Chamber for Nurses and Midwives in 2019**. Midwives were trained in effective communication with women, emphasising emotional support of women in labour, active listening and an empathetic approach to their needs. The workshop's goal was, through discussion and other interactive activities, to contribute to the professional discourse and raise the awareness of participating midwives about women's rights, gender equality and unbalanced access to power, as well as about good practice in the field of maternity care that is evidence-based.

Human rights public discussions[267] were **organised by the Citizen, Democracy and Accountability and Women's Circles in five towns in Slovakia in 2019**. Students of medical study programmes (nurses and midwives) were the target group. The public discussions were about the conditions in which women give birth in healthcare facilities in Slovakia and the (dis)respect of their human rights in connection with childbirth. The society-wide discussion gained momentum after the release of director Zuzana Límová's documentary film 'Medzi nami (Before I Met You)' in Slovak cinemas. The public discussions used the film to boost the discussion with future healthcare professionals.

Relevant initiatives to support women in the exercise of their reproductive rights.

The **government agreed** to the **parliamentary** proposal that **a woman has the right to the presence of an accompanying person during childbirth**. If the medical facility conditions allow it, the woman should also be allowed the company of several people. The declared incentive for drafting the parliamentary proposal is the lack of legislation to ensure the right of mothers to have persons of their choice present during childbirth. The **public defender of rights pointed out the absence of legislation and recommended legislation in this area**. The proposal also allows the possibility of limiting the presence of persons, namely the attending physician, to the necessary extent and for the required time, taking into account the nature of the medical procedure. The amendment to the law is proposed to take effect from 1 June 2024.

Relevant initiatives to deconstruct general assumptions on childbirth

Transgender people are a hard-hit group due to violations of their sexual rights, including forced surgical sterilisation due to Christian ideology and gendered stereotypes. Despite a long-term fight for improvement and partial success, their situation continues to be intolerable and the outlook tends to be negative.

Until now, **Slovakia is one of the last European countries that required transgender people to undergo surgical castration** (removal of reproductive organs) when legally changing their gender (and therefore changing their name and birth number). At the same time, there was no legal regulation of this process. Slovak transgender people and LGBTI+ organisations have been trying to

266 http://odz.sk/nasa-spolupraca/.

267 http://odz.sk/ludskopravne-diskusie/.

change this situation for more than a decade.[268]

In 2019, a **group of experts** from various **medical fields** finalised a document entitled '**Professional guidance of the Ministry of Health of the Slovak Republic on the unification of medical procedures** when issuing a medical opinion in case **of gender reassignment'**. The document subsequently received the support of the Committee of the Slovak Psychiatric Society, which brings together experts in the field of psychiatry in Slovakia. Despite this, the Ministry did not accept this document during the tenure of three different ministers.[269]

Finally, after the professional societies called on the Ministry again to adopt the guideline because the current situation threatened the provision of healthcare to transgender people and after several modifications, **the guideline was finally approved by the Minister on March 2022** and is published in the *Journal of the Ministry of Health of the Slovak Republic*.[270]

The guideline **regulates the gender transition process and strengthens legal certainty and transparency**. It would enable the training of new specialists, thereby increasing the availability of healthcare for transgender people. The most relevant success of the guideline is that it abolishes the practice of forced surgical sterilisation. According to **the new rules, transgender** people can **choose between surgical procedures and hormonal treatment** combined with a test of **living in their preferred gender for at least one year**.[271]

Despite that Slovakia's first comprehensive gender reassignment protocol and the establishing guidelines for gender recognition was signed and published and received a broad welcome from health professionals and the transgender community, the **move** has **attracted** numerous **transphobic comments**, with pressure led by some conservatives. The Health Ministry suspended the document's validity in May 2022.[272]

Moreover, in November 2022, some **fundamentalist Christian NGOs** submitted a **petition to the Slovak Government** requiring them to **withdraw the guideline** forever and make it impossible to carry out any gender transitions and rewrite gender in Slovak territory. They want conversion therapies to be carried out in Slovakia. This happened less than a month after a terrorist attack in which two queer people were slaughtered in Bratislava.[273]

268 Iniciatíva Inakosť (2022).
269 Iniciatíva Inakosť (2022).
270 Iniciatíva Inakosť (2022).
271 Iniciatíva Inakosť (2022).
272 Iniciatíva Inakosť (2022).
273 Slovak Spectator (2022).

4.9.3 Other relevant initiatives

In **July 2019, the UN Special Rapporteur against violence against women**, Dubravka Šimonović, presented her **report to the UN General Assembly** on the human rights approach to **mistreatment and violence against women in reproductive healthcare,** with a focus on childbirth and obstetric violence.[274]

The report, naming Slovakia and referring to monitoring studies prepared by Slovak NGOs, describes the **current pattern of violence and other mistreatment of women in the delivery of maternity care** in health facilities worldwide. The report also specifically deals with **obstetric violence concerning women who belong to various minorities** or face various disadvantages, including **Roma** women, **women with disabilities** and women with a **lower socioeconomic status**. Many problems or shortcomings have been present for a long time in Slovakia as well.[275] The report was promoted and used by several NGOs for their advocacy for improving the conditions of giving birth in Slovak hospitals.

4.10 Conclusions and recommendations

Slovakia lacks proper and complex **legislation and regulations and regular independent control mechanisms to prevent and eliminate obstetric violence and the violation of human rights related to childbirth**. Awareness of human rights in connection with the provision of antenatal, delivery and postnatal care on the part of responsible institutions and bodies is relatively low and the topic of obstetric violence has **started to be recognised** by the state authorities only **slowly and recently**. The topic, however, resonates among women, who use the only-women spaces in social media and platforms created by dedicated women's rights organisations to discuss it.

Slovakia is **failing in systematic data collection** on human rights violations in the provision of prenatal, birth and post-partum care and is lacking initiatives, proactive actions and systemic approaches from state institutions and responsible control bodies.[276] Further development of the issue can build on the previous initiatives of dedicated NGOs, documentaries and media coverage, which contributed considerably to increasing awareness of the violation of human rights during childbirth. The public and some of the professional bodies (mainly midwives) are sensitised to change and improvements.

There have been improvements in some areas, for example, in relation to the perception of the behaviour of medical staff towards women in labour, it has been noted that respect for women was missing. Another positive development is the recently adopted law that regulates the right to the presence of an accompanying person during childbirth.[277]

Based on the previous independent initiatives and findings of several surveys, **the following recommendations are proposed to improve** the situation in Slovakia on obstetric violence:

- **Ensure** the provision of **healthcare** in a way that **respects the human rights, human dignity, mental health and emotional wellbeing** of women during childbirth.

274 Šimonović (2019).

275 Šimonović (2019).

276 Debrecéniová (2021a).

277 Žureková (2022).

- **Ensure effective implementation and control of legal and administrative procedures** and practices related to informed consent in maternity care following recommendations of the UN Special Rapporteur on the right of every person to the highest attainable level of physical and mental health.
- **Systematically collect data** on maternity care and **regularly publish data**.
- **Adopt standards in the field of obstetrics** that will **take** into **account scientific** and medical development while **fully respecting women's rights**.
- **Ensure adequate financial resources for healthcare facilities** to ensure a dignified environment for women in labour and satisfactory working conditions for healthcare providers.
- **Implement training for healthcare workers** to increase awareness of the issue of human rights and violence related to childbirth.
- **Introduce effective** measures that ensure an effective **investigation and monitoring** of the **segregation of Roma women in maternity care**, stopping the practice and punishing those responsible.
- **Create** an effective **system of control for mothers and general patients**, in the event of a **violation of basic human rights**, to **guarantee** independent review and the **sanctioning** of relevant institutions and which will ensure **compensation and redress for affected persons**.[278]

278 Thominet (2021).

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5.1 Overview

The Spanish **National Health System** (NHS) is financed by general state budgets. Spaniards and foreign citizens who have established their residence in the national territory are holders of the right to health protection and healthcare.[279] The NHS **includes** in its portfolio **services for pregnancy, childbirth and post-partum care**. The responsibility for the **territorial planning and the provision of health services corresponds to the 17 regional governments,** the Autonomous Communities. Voluntary private insurance is independent of the public system and has a variable population coverage among the different Autonomous Communities. In the last two decades, **a very stable proportion of births** – **four out of five births** – **has been attended in the NHS**, while one in five births has been attended in private centres.[280] Practically all births are attended in hospitals, except for two midwifery-led birth centres for low-risk births[281] and a residual and stable 0.3 % of women who give birth at home.[282] The home birth option is not included in the portfolio of public services; still, some women choose this option and are attended mostly by private midwives.

Spanish perinatal indicators are in general very close to the average of European countries – **with a stable caesarean section rate of around 25 % since 2007 and a perinatal mortality of 2.5 per 1 000 births in 2019**. **Spain** is, **however, one of the countries** in the European context **that practises** some interventions the **most** – e.g. **instrumental deliveries**.[283] Nevertheless, despite **women's right to achieve the highest level of sexual and reproductive health**, recognised in Article 95 of the Beijing Declaration,[284] **in Spain**, as in most middle- and high-income countries, **rates of non-medically justified obstetric interventions** – e.g. **caesarean sections, episiotomies or induction of labour** – **are high and have been exceeding for decades what is recommended by the World Health Organization**.[285]

The high prevalence of **unjustified obstetric interventions**, the over-medicalisation of childbirth in general and poor maternal experiences, highlighting practices of **gender discrimination** in childbirth care, led to the **founding of**

279 *Law 14/1986*. Available at: https://www.boe.es/buscar/act.php?id=BOE-A-1986-10499
280 Ministerio de Sanidad (2022).
281 FAME (2020).
282 INE (2022).
283 Euro-Peristat (2022).
284 UN (1995).
285 WHO (1985).

women's organisations – such as the association Vía Láctea, [Milky Way] in 1987 or El Parto es Nuestro [Childbirth is Ours] in 2003. **Civil mobilisation – with considerable media and public policy impact – on obstetric care started to take place in Spain in the 2000s**.[286] The public debate led the Ministry of Health in 2006 to initiate the **development of the *Strategy for Normal Birth Care*, from now on the *Strategy*,** aimed at (public) hospitals of the NHS. **All relevant stakeholders took part in the process**, coordinated by the Women's Health Observatory: **social and women's organisations, scientific and professional societies, Spanish regions and experts.** As stated by the Ministry of Health, **the *Strategy* was a response to a social, professional and health administration demand**, manifested in the presence of the progressive medicalisation and increase of unnecessary and unjustified interventions in a physiological process with repercussions on health.[287]

With the **general objective of improving the quality of care while maintaining safety levels**, the Strategy, approved in 2007, considered four strategic lines: to **promote clinical practices based on the best available scientific evidence**, to **encourage the participation of female users in decision-making**, to promote the specialisation and **continuous training of professionals** and, finally, to promote **research, innovation and dissemination of good practices**.[288] Thereby, actions were implemented to train and sensitise health providers and different **guidelines** were prepared that promoted a model of attention to childbirth focused on the physiology of the process and the needs of women and their families. These actions helped to incorporate new beneficial practices and to progressively abandon some of those without evidence of the benefits they provide or that, applied routinely, are harmful, such as episiotomy. Although the ***Strategy* was proven to be effective in curbing the escalation of caesarean sections while preserving perinatal safety in NHS hospitals**[289] and some obstetric interventions – such as episiotomy – decreased drastically, the ***Strategy* was not enough to adapt clinical practice to recommended standards**. Thus, years after its approval, the rates of instrumental deliveries, inductions, episiotomies or Kristeller manoeuvres continued to be well above what was recommended[290] and women's experiences continued to be marked by a lack of autonomy, namely, the **violation of their right to decide**.[291]

At present, **obstetric interventions rates are still well above that recommended by health institutions** – such as WHO or the Spanish Ministry of Health.[292] In addition, maternal experiences continue to show that there is a large number of **uninformed, coercive, unconsented or even judicially forced medical interventions** when the woman has explicitly rejected them. These practices constitute a **violation of their physical and moral integrity** and evidence **women's lack of autonomy during childbirth**.[293]

The **strong awareness raised by Spanish women's organisations** regarding rights in childbirth – some of the most representative at the present time being Childbirth is Ours and the Observatory of Obstetric Violence – has allowed sev-

286 Villarmea et al. (2016).
287 Ministerio de Sanidad (2007).
288 Ministero de Sanidad (2007).
289 Recio Alcaide & Arranz (2022).
290 Ministerio de Sanidad (2012).
291 OVO (2016).
292 Ministerio de Sanidad (2021).
293 Mena-Tudela et al. (2020).

eral Spanish women to denounce the mistreatment received during childbirth. Consequently, in the first two **Resolutions adopted by the CEDAW Committee regarding victims of obstetric violence, the State party was Spain** – the case *S.F.M. v. Spain* in 2020[294] and the case of *N.A.E. v. Spain* in 2022.[295] In both cases, the CEDAW Committee recalls the obligation of the State to abolish customs and practices that constitute **discrimination against women** and considers that stereotyping affects the right of women to be protected against obstetric violence.[296]

In recent years, Spanish birth **activism has placed the issue of obstetric violence on the feminist and equality policy agenda** and there has been a **heated debate regarding the inclusion of obstetric violence in national legislation[297] or in regional legislation**, such as of the Autonomous Communities of Valencia[298] and La Rioja.[299] The **tension between the resistance and/or denial of some health practitioners and professional bodies** – mainly the Spanish Society of Gynaecology and Obstetrics (SEGO) and the General Council of Official Colleges of Physicians (CGCOM) – of the need to implement legal and medical measures to eliminate obstetric violence,[300] on the one hand, and **activists' call to legislate the phenomenon**,[301] **together with other professional bodies** – such as the Federation of Associations of Midwives of Spain,[302] the Catalan Society of Obstetrics and Gynaecology, the Council of Medical Associations of Catalonia[303] and other medical, nursing or psychology student associations,[304] on the other hand, is manifest.

In 2020, at the initiative of Childbirth is Ours and the Observatory of Obstetric Violence,[305] a series of contacts between women's associations and the Ministry of Equality began, with the aim of ensuring that Spain complies with the recommendations on obstetric violence by international organisations, such as the UN and WHO.[306] **In 2021, the Ministry of Equality announced the inclusion, in the reform of the *National Organic Law 2/2010 of Sexual and Reproductive Health and of the Voluntary Interruption of Pregnancy***, of the term 'obstetric violence' to address the phenomenon.[307] **Nevertheless**, **the term 'obstetric violence' has been excluded from the final Reform, due to the refusal of** the cited **professional bodies** and the Ministries of Health and Justice, which said they were not feeling comfortable with the term.[308] **In the final Reform, the Law** considers a chapter on the 'Protection and guarantee of sexual and reproductive rights in the gynaecological and obstetric field', which

294 CEDAW (2020).
295 CEDAW (2022).
296 A third Resolution by the CEDAW Committee regarding victims of obstetric violence in Spain was published in 2023 (CEDAW 2023). Its content has not been included in this country case as the Resolution was published after the report was delivered.
297 El Diario (2022c).
298 El Diario (2021b).
299 Nuevecuatrouno (2022).
300 El Salto (2021).
301 El parto es Nuestro (2022a).
302 FAME (2022).
303 SCOG and CCMC (2022).
304 AEEE, CEP-PIE, & CEEM (2021).
305 El Parto es Nuestro (2020a).
306 Europa Press (2021).
307 El Diario (2021a).
308 El Diario (2022c).

addresses some manifestations of obstetric violence, such as the lack of informed consent or the 'inappropriate or unnecessary gynaecological and obstetric interventions', **but avoids the use of the term.**[309] The exclusion of the term "obstetric violence" from the final text of the Law has been made **despite the advice of the Public Prosecutor's Council**, which recommended **that gynaecological and obstetric violence – as a form of violence against women** in the reproductive sphere – **be included in the reform of the Law**;[310] **and despite the 35 textual mentions to obstetric violence in the amendments**[311] prepared by the political parties **to the earlier Draft**. In any case, **Spain already acknowledges the term 'obstetric violence' in regional laws**: **since 2020**, **in** the *Law 17/2020 of the Right of Women to Eradicate Sexist Violence*[312] of the Autonomous Community of **Catalonia**; and **since 2022**, **in** the *Law 1/2022 of Equality of Women and Men*[313] of the Autonomous Community of the **Basque Country**.

Spain is an interesting case study of responding to obstetric violence in the European context because of its **political and legislative achievements in the area, and the crucial contribution of civil society to raise social and professional awareness about the occurrence of obstetric violence in Spain (and beyond).**

5.2 Definitions and references in the country

The Law of the Autonomous Community of **Catalonia defines obstetric violence as a form of gender-based violence** that:

'consists in **preventing or hindering access to truthful information, necessary for autonomous and informed decision-making**. It can affect different areas of physical and mental health, including sexual and reproductive health and may prevent or make it difficult for women to take decisions about their sexual practices and preferences and about their reproduction and conditions in which it is carried out, in accordance with the assumptions included in the legislation. **It includes forced sterilisation, forced pregnancy, prevention of abortion in the legally established assumptions and the difficulty in accessing the contraceptives methods, methods of preventing sexually transmitted infections and HIV and assisted reproductive methods, as well as gynaecological practices and obstetrics that do not respect the decisions, the body, the health and the emotional processes of the woman**'.

The term 'obstetric violence' is also recognised in the Law of the Autonomous Community of the **Basque Country**, **even though it only names obstetric violence as one among other forms of violence against women**. The law also considers the incorporation of **measures to promote the autonomy of women in pregnancy, childbirth and breastfeeding**.

Furthermore, although the term **obstetric violence is not explicitly mentioned in other institutional documents** (official guidelines, studies or statements), **some of its manifestations are addressed in the Reform of the**

309 Gobierno de España (2022).

310 Consejo Fiscal (2022).

311 *BOCG Num. 122-2*. https://www.congreso.es/public_oficiales/L14/CONG/BOCG/A/BOCG-14-A-122-2.PDF#page=1.

312 *Law 17/2020*. Available at: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2021-464

313 *Law 1/2022*. Available at: https://www.boe.es/buscar/doc.php?lang=en&id=BOE-A-2022-4849

National Organic Law 2/2010. The protection and guarantee of sexual and reproductive rights in the gynaecological and obstetric field is articulated in Title III, Chapter II, where Article 27 states that public services will devote special efforts to: (a) **mandatorily require the free, previous and informed consent of the women** in all invasive treatments during delivery care; (b) **reduce interventionism, avoiding unnecessary and inappropriate practices** that are **not supported by scientific evidence**; (c) **provide respectful treatment** and clear and sufficient information; and (d) guarantee the **non-separation of newborns from their mothers and other people with a direct link to them**, when unnecessary. In Article 28, the Law states that the Health Administrations will promote the **carrying out of studies on practices in the gynaecological and obstetric field that are contrary to the principles established in the previous article and in the national and international recommendations on respectful childbirth**. Article 29 articulates **training of personnel** of gynaecology and obstetrics services **to respect and guarantee women's rights.** Finally, Article 30 establishes that the **Sexual and Reproductive Health Strategy will include a section on prevention, detection and comprehensive intervention to guarantee sexual rights in the gynaecological and obstetric field** and that a **Common Protocol of Actions** will be approved to this end, which will be taken as a framework by **Autonomous Communities for the prevention of praxis contrary to what is established in** Chapter II of the Law.

Also, the *Strategic Plan for Effective Equality between Women and Men 2022–2025*[314] of the Ministry of Equality includes the action to '**guarantee prenatal, birth and postnatal care that respects human rights and the will of women**', mainly by defining and responding to '**violence in the sexual and reproductive sphere as well as inappropriate or unnecessary gynaecological and obstetric interventions** within the framework of the reform of the *Organic Law 2/2010 of Sexual and Reproductive Health and Interruption of Pregnancy*'.

Even if the topic of obstetric violence is institutionally addressed, there is a **distance between the current institutional approaches in Spain**, both on the regional and national level, and **the approach of birth rights activism and international organisations**, such as: **WHO** in 2014, in the *Prevention and elimination of disrespect and abuse during facility-based childbirth* statement;[315] the **United Nations** in 2019, in the *Report of the Special Rapporteur on Violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*;[316] the **Council of Europe** in 2019, in its *Resolution 2306 of October 2019* on *Obstetric and gynaecological violence*;[317] the **CEDAW Committee** in its Views of 2020 and 2022;[318] and the **European Parliament** in 2021 in its View of 21 January 2021, on the *EU Strategy for Gender Equality*.[319]

The definitions of and references to, obstetric violence, as they are found in the aforementioned declarations of international organisations, all **locate 'obstet-**

314 Ministerio de Igualdad (2022).

315 WHO (2014a).

316 UN (2019).

317 Parliamentary Assembly (2019).

318 CEDAW (2020; 2022).

319 European Parliament (2021).

ric violence' at the axis of human rights violation, gender-based violence and clinical malpractice, considering elements of both **respectful treatment and quality care**. In all of them, the term 'obstetric violence' refers to **disrespectful and abusive treatment, systematic deprivation of women's right to autonomy and other elements of poor-quality care, such as failure to adhere to evidence-based best practices,** that women may experience from healthcare providers during pregnancy, childbirth and the post-partum period.

Despite the above declarations, **this type of gender-based violence and** their underlying **gender stereotypes remain invisible** to an important part of society, which understands gender-based violence's most severe manifestations as an exceptional confluence of concrete factors, instead of as a result of **structural inequalities** derived from the core prevalent idea of **women´s inferiority and subordination**.[320] **The term 'obstetric violence' has the potential for addressing these structural and gender dimensions of the phenomenon** and frames the discussion of abuse and disrespect within the **broader field of structural inequalities and violence against women.**[321] It also **validates the lived experiences** of those who were subjected to this form of violence, including professionals who witnessed it.[322]

For these reasons, the **ambiguity of the Spanish approach** can be seen. In the national approach, it does not fully acknowledge the term and its references in the international framework and **ignores its basis of gender discrimination and other structural causes**, therefore disregarding key policy recommendations made to the States to address its driving factors and **leaving the legislative initiative without crucial tools to eradicate** the phenomenon. In the regional approach, although the Catalan Law recognises and defines in detail obstetric violence as violence against women, it does not consider international recommendations **and does not formulate the needed specific guarantees to address its structural causes**. The Basque Law also falls short by not considering the structural causes of obstetric violence and addressing **the autonomy of women only as something to be promoted instead of to be guaranteed.**

5.3 Data collection and evidence on obstetric violence in the country

Bringing mistreatment and violence against women in reproductive health services **to the surface** requires information that accurately depicts **a violence that is socially normalised**. **The occurrence of obstetric violence in Spain is evidenced mainly through the perinatal indicators of official statistics** – which account for the prevalence of unnecessary and dangerous obstetric interventions. It is also present in **academic research**, **media analysis and news** and **publications by birth rights associations**. Such information challenges customs, practices and beliefs that, even if normalised, constitute violence and/or discrimination.

5.3.1 Empirical evidence (quantitative and qualitative)

Official indicators reveal the generalised use of non-evidence-based clinical practices in Spain (see table below). The evaluation, carried out years after the approval of the *Strategy for Normal Birth Care*, showed that **none of the obstetric interventions for which a measurement was made complied with**

320 Lorente Acosta (2020).

321 Sadler et al. (2016).

322 Verity and Pickles (2022).

the standards set by the Ministry of Health for the evaluation, except for the application of the epidural. Medical practices used to accelerate labour – such as **oxytocin administration, amniotomies, Kristeller manoeuvres, episiotomies and instrumental births** – are used much more frequently than necessary, putting the mother's and baby's health in danger, as the Ministry of Health warned.[323] Note that we refer to 2012, as this year is the only with an official source of information available for several indicators in the table. For those indicators for which there are subsequent updates, such as the caesarean section or episiotomy rates, their evolution has been added in the 2018 column.

Table 4: Process and results indicators on obstetric interventions comparison to standard in NHS hospitals, 2012–2018

Process and result indicator	Result 2012	Result 2018	Ministry of Health Standard
% of amniotomies performed	46.6 %	(*)	Do not perform routinely
% of spontaneous labours with oxytocin administration during labour	53.3 %	-	5–10 %
% of induced labours	19.4 %	34,2 %	< 10 %
% of births with a fully completed partogram sheet	52.1 %	-	100 %
% of births with locoregional analgesia	72.2 %	-	30–80 %
% of vaginal births with lithotomy position was maintained throughout expulsive	87.4 %	-	< 30 %
% of vaginal births in which the Kristeller manoeuvre has been performed	26.1 %	-	0 %
% of episiotomies in normal births	41.9 %	(**)	< 15 %
% of protocols that include all the recommendations for care during normal birth	15.5 %	-	100 %
% instrumental births	19.5 %	18.8 %	< 15 %
% births with vacuum	10.2 %	13.1 %	< 7 %
% of forceps births	6.1 %	3.9 %	< 5 %
% births with spatulas	3.2 %	-	< 5 %
% caesarean sections	22 %	21.8 %	< 15 %
% vaginal births after caesarean section	44.2 %	-	60–80 %
% of women surveyed who say they were not separated from their newborn	50.2 %	-	≥ 80 %

Source: Author, based on the Report on Delivery and Birth Care in the National Health System 2012, Ministry of Health[324] and the Report on Perinatal care in Spain, 2010-2018.[325]
(*) % of amniotomies performed and % of births with locoregional analgesia are clearly under-registered in the 2018 source, as noted by the Ministry of Health.[326] For this reason, and in order to avoid confusion, these data are not included in the table.

(**) This indicator is not available for 2018. If we consider the percentage of episiotomies over total vaginal deliveries instead of over total normal deliveries (which do not include instrumental deliveries) the 2012 indicator would be 40% and the 2018 indicator would be 27.5%.

323 Ministerio de Sanidad (2012).
324 Ministerio de Sanidad (2012).
325 Ministerio de Sanidad (2021).
326 Ministerio de Sanidad (2012).

More recent indicators collected by the Ministry of Health show that, although the episiotomy rate in NHS has become closer to quality standards – the **episiotomy rate decreased** to 27.5 % in 2018 – other indicators such as **induced births have increased** from 9.5 % in 1997 to 34.2 % in 2018.[327] Furthermore, **caesarean section rates remain stable and persist well above the reference standards** (< 15 %): 22 % in NHS hospitals and 36.5 % in the private sector – and are **alarmingly high in some hospitals,** with rates over 50 %.[328]

Regarding the variability of obstetric interventions across regions, it is worth recalling that competences in health in Spain are transferred to the Autonomous Communities. Caesarean section rates are **widely variable in Spain and consistent across time**. In 2020, the last year available, the Basque Country is the Autonomous Community with the fewest caesarean sections and one of the two, together with Navarra, that comes close to the reference rate, with 14.8 %; while Extremadura reaches the maximum, with 31.9 % of births being by caesarean sections.[329] Although the average age of mothers is lower in Extremadura than in Basque Country, a woman has twice the chance of undergoing a caesarean section if she gives birth in Extremadura than in Basque Country. In addition, the variability in rates between Autonomous Communities can also be observed between public and private hospitals: systematically in each Autonomous Community, **caesarean section rates are significantly higher in private than in public hospitals** – **a fact with no medical justification**, since it is the public health system that attends most of the high-risk births that are more likely to end up in caesarean sections. In general, **the private healthcare system is more likely to perform more instrumental births and more episiotomies than the public system**.[330]

Regarding obstetric violence prevalence, **38.3 % of women reported having suffered it** while giving birth or in the post-partum period, according to recent survey in Spain.[331] Of all the surveyed women (17 541), **45.9 % indicated that they were not informed about the procedures they had been subject to, nor were asked to provide express consent**; 34.5 % stated that they **were criticised** for their behaviour with **ironic or discrediting remarks**; 31.4 % had been **treated with nicknames or childish diminutives**; 48 % indicated that they found it **impossible to resolve their doubts**, or to voice their fears or concerns; 44.4 % perceived that they had undergone **unnecessary and/or painful procedures** and of these, 52.3 % were **neither provided with reasons nor asked to give consent** and 31.1 % were provided with reasons, but were **not asked to give consent**. Thus, a total of 83.4 % were **not requested to provide informed consent**.

Of those women who suffered miscarriage or perinatal loss (n=1 108), 36.5 % perceived **unnecessary or unjustified care** and 70.8 % of the cases did **not feel they had received physiological support during the process**. Of all the participants, 35 % answered that they did **not feel they received any support during the post-partum** period in their questions about feeding and baby care. Of those who chose breastfeeding, 7.6 % did **not feel they were supported or helped** to resolve doubts or overcome difficulties. Regarding interventionism and medicalisation during birth, **women giving birth in private healthcare**

327 Ministerio de Sanidad (2021; 2012).

328 El Diario (2022a).

329 Ministerio de Sanidad (2022).

330 Recio Alcaide (2015).

331 Mena-Tudela et al. (2020).

had a higher interventionism rate, less satisfaction, felt more insecure and vulnerable and perceived more obstetric violence.[332] Other investigations point out that women in Spain can be **victims of obstetric violence regardless of their age, educational level and socioeconomic status**, but women who have a **high level of support from their partner** are less likely to experience situations of verbal and psychological types of obstetric violence.[333]

5.3.2 Relevant manifestations

Manifestations of obstetric violence in Spain can be grouped in three categories: **deprivation of the right to autonomy during the stay at a healthcare facility; non-evidence-based clinical practices;** and **other manifestations of disrespect towards women in labour**, such as verbal abuse or lack of intimacy and contact between mother and child. They all **have in common the subordination of women and the violation of their right to health and respect in their decisions**.

Deprivation of the right to autonomy

The autonomy of women during childbirth is guaranteed in Spain by *Law 41/2002 of Patient Autonomy*,[334] which in Article 8 on Informed Consent establishes that '[a]ny action in the health of a patient **requires the free and volunteered consent** of the affected, **once they, having received the information** provided for in Article 4, **have assessed the options of the case**'. Further to this, Article 9 b) states that, in life-threatening situations **in which it is not possible to obtain the patient's consent**, doctors can act on their behalf without having to consult them, although they must consult their relatives or close friends. It is worth noting that this does not mean doctors can act against the patient's decisions whenever there is an emergency situation, but that this can only be done if, **in addition to the vital emergency, the person is unable to express herself**.

Informed consent for medical treatment related to reproductive and birth services is a fundamental human right.[335] Women have the right to receive full information about recommended treatments so that they can make informed and well-considered decisions.[336] Nonetheless, the lack of informed consent or its misuse is often reported by Spanish women and takes many forms.[337] Irrespective of the law**, a common belief of medical professionals in clinical settings is that parturients do not need to make informed decisions, and that instead they mostly have simple preferences which can be 'granted or rejected by the practitioner'**.[338] **Rather than using the literal legal notion of 'free and informed decision-making'** contained in the current *Law 41/2002,* some **alternative expressions are used to reduce women's decision-making**, such as '**participating** in decision-making', 'decisions will be adopted **jointly** between the doctor and the patient' or 'the patient will always

332 Mena-Tudela et al. (2021).

333 Martínez-Galiano et al. (2021).

334 Law 41/2002 of Patient Autonomy: https://www.boe.es/buscar/act.php?lang=es&id=BOE-A-2002-22188&tn=1&p.

335 UN (2019).

336 UN (2019).

337 Mena-Tudela et al. (2020).

338 Fernández Guillén (2018).

be informed prior to the intervention'.[339] In the paragraphs that follow, different forms of women's right deprivation of autonomy in Spain will be dissected, from the less severe to the most blatant, i.e., explicitly forced obstetric interventions.

A first form of a lack of informed decisions consists of **not informing women about obstetric intended interventions, different options, or consequences, as well as not requesting informed consent** – **acting therefore without women's consent**. Research has shown that these ways of violating service user's autonomy are not exceptional in Spain: according to the Spanish Observatory of Obstetric Violence,[340] in more than half of the cases (50.7 %), **women were not informed of the obstetric intervention** (e.g., induction, Kristeller manoeuvre or episiotomy) that was going to be performed. In 60.8 % of the cases, **they were not told why a certain manoeuvre was recommended**. In 76.6 % of the cases, they were **not informed of the different options** for action (including the expectant attitude). In general, the possible consequences (80.4 %) or the secondary effects of the intervention (84.6 % of the cases) were **not explained**. Finally, in half of the cases (50.1 %) health providers **acted without the subject's consent**.

Testimonies help bring light to how the lack of request for informed consent occurs. **Testimony 1 in Annex 2** relates to a woman giving birth in 2015, whose **informed consent was not requested** for an amniotomy, who was also **coerced into undergoing** a Kristeller manoeuvre[341] three times, and who was insulted for rejecting it.[342]

A similar experience, but from 2013, was published by the non-governmental organisation Childbirth is Ours. **Testimony 2 in Annex 2** is from a woman whose informed consent was not requested for a Kristeller or an episiotomy or a vacuum, while she was **accused** of not pushing better.[343]

These testimonies are by no means exceptional. Many similar stories, reporting a lack of the right to make informed decisions, have been gathered, classified and published throughout the years by the association Childbirth is Ours and can be read online.[344] Especially dramatic is **Testimony 3 in Annex 2**, where N.N.'s lawyer, reports that when she went to give birth to her first daughter in 2011, several trainee doctors used forceps on her for the sole purpose of learning how to use them, causing very serious injuries to the baby's head and health.[345]

The above testimonies show **subordination**, **lack of decision-making** and **defencelessness**. They also show discomfort when being **insulted and punished** – '*hysterical*' –, when **challenged as incapable** – '*before you pushed better*' –,

339 Fernández Guillén (2018).

340 OVO (2016).

341 The Kristeller manoeuvre (fundal pressure) continues to be a common practice in Spain, with a rate reaching up to 26 % in vaginal deliveries (Ministerio de Sanidad 2012) and is totally discouraged in the Clinical Practice Guide for normal childbirth of the Spanish Ministry of Health (Ministerio de Sanidad 2010b) and by WHO, in recommendation 40 of the WHO recommendations on intrapartum care for a positive childbirth experience (WHO 2018a).

342 OVO (2016).

343 Testimony available at:

https://www.elpartoesnuestro.es/relatos/los-peligros-de-querer-decidir-por-una-misma?field_centro_value=&field_story_tax_tid %5B %5D=4715&sort_by=field_count_value&sort_order=ASC.

344 Testimonies are available in the testimonies section at:

https://www.elpartoesnuestro.es/relatos?field_story_tax_tid %5B0 %5D=4715&field_centro_value=&sort_order=ASC.

345 Fernández Guillén (2018).

or when the professional shows a **haughty attitude** – '*she stood with her arms crossed behind the midwife and ordered him to make me an episiotomy*'. Above all, women describe a feeling of being **powerless**, a **fear** of real danger typical of those who are not empowered in a situation but are instead made passive – '*Not like that, you can "break her head".'*

In these situations, information was not given to women and medical actions were taken directly without asking them, thus infringing the right to make informed decisions and **reinforcing gender stereotypes about women's subordination**, as if they are **passive or unable to decide about their own health and reproductive processes**. But the most **severe violations of the right to autonomy and integrity** in maternity care take place when women are forced to accept particular interventions despite explicitly refusing them. In certain cases, in Spain, **women have been threatened by their health providers with the request of a court order to coerce them to undergo an induction or caesarean section**.[346] As a consequence of these cases, a statement was signed by 16 Spanish NGOs in February 2020,[347] warning of the dangers of judicialization and criminalisation of childbirth in Spain.[348]

These threats have come true in situations in which **women have been forced by a court order to a hospital admission for immediate induction of childbirth or to undergo a forced caesarean section**. In the so-called 'Oviedo case' in April 2019, the judge of the Court of Instruction No 1 of Oviedo, a city in Northern Spain, ordered the transfer to the Central University Hospital of Asturias (HUCA) of a woman 'who had exceeded 42 weeks of pregnancy'. The woman had gone to the hospital to perform a foetal wellbeing check-up because she had passed 42 weeks of gestation. The Maternity Service proposed that she had an induction, as it was what is technically called a 'chronologically prolonged gestation'. Instead, the pregnant woman returned home, where she had intended to give birth with her midwife and went into labour naturally. That same afternoon, local police officers showed up at her home with a court order, issued at the request of the HUCA's Sub-directorate of Critical Surgical Services. The reason for her forced admission was the need to perform an 'immediate labour induction'. However, 36 hours passed before a caesarean section was finally performed.[349] The Constitutional Court of Spain endorsed in June 2022 the compulsory admission of the pregnant woman to give birth in HUCA,[350] a sentence that was strongly criticised by feminist groups.[351] This case is a good example of how women's lack of rights to autonomy and physical integrity is active not only in clinical settings, but also in judicial settings – where gender stereotypes are reproduced – while *Law 41/2002* states that citizens are holders of those rights even if there is a medical indication for an intervention. Another case of being forced by a court order to an immediate intervention happened in Elche, a city in Eastern Spain, in September 2019, when a court order forced a pregnant woman – who had refused the surgery – to undergo a caesarean section[352] in disregard of the *Law of Patient Autonomy*.

346 Brigidi & Busquets-Gallego (2019).

347 The statement addressed to leading Spanish institutions in the field of health and equality can be read here: https://www.elpartoesnuestro.es/sites/default/files/public/official_statement_epen.pdf.

348 El Parto es Nuestro (2020b).

349 El País (2019); La Voz de Asturias (2019).

350 Expansión (2022).

351 El Parto es Nuestro 2022b; OVO 2022).

352 El Español (2019).

In addition, some forced caesarean sections occur without the mediation of the judicial power – they are **simply performed against the explicit decision of the woman, by ignoring her or her (desperate) request**. This is the case of a woman who gave birth at the beginning of the Covid-19 pandemic. Her harsh testimony[353] (see **Testimony 4** in Annex 2) allows us to understand what happened: she was about to give birth vaginally, but suddenly realised that the medical team was preparing to perform a caesarean section. She begged not to have it done and not to be ignored. But, without answering her, they performed it. As reported, the gynaecology department of the hospital had activated a protocol only two days earlier, according to which any birthing woman infected with coronavirus had to undergo a caesarean section. The reason for the protocol was assuming that a caesarean section is shorter in time than a vaginal delivery and hence the risk of contagion for the staff would be lower. And so, without any explanation, they dragged her into the operating room and performed a caesarean section on her that she did not need.[354]

Non-evidence-based clinical practices

Common medical practices that are not based on scientific evidence, whether used to **accelerate childbirth** – as **time is a scarce resource in birth care**[355] – or to **improve the comfort of health providers, to the detriment of the good course of birth and the safety and wellbeing of the parturient (and baby)** – such as the lithotomy position during the expulsive, the lack of intimacy or accompaniment, the use of haloperidol, the inclination to programme births – are:

Episiotomy: An episiotomy is a **deep cut in a woman's perineum** that reaches the pelvic floor muscle to surgically assist the parturient to have a vaginal delivery. Although this procedure can be beneficial for the baby and the mother if medically necessary, if not needed or done without the informed consent of the mother, it can have severe physical and psychological effects on the mother and constitute gender-based violence, an act of torture and inhuman and degrading treatment.[356] Episiotomy and post-partum suture, when performed without informed consent and without anaesthesia, can have significant repercussions on the person's sexual and reproductive life and mental health – the scars resulting from this practice can be present for the rest of her life.[357] Among episiotomy potential adverse effects are anal sphincter dysfunction, urinary incontinence, dyspareunia (pain during sexual intercourse) and a higher frequency of third- and fourth- degree tears.[358] Episiotomy rates in Spanish **public hospitals** decreased from 77.7 % in 1997 to **around 28 % in 2018**,[359] but **the standard of the Ministry is under 15 %**.[360] In **private** healthcare, the rates are **higher than in the NHS**.

353 Podcast Parir en el Siglo XXI [Giving birth in 21st century], Chapter 5 (Part 1): 'Name it': https://www.rtve.es/play/audios/parir-en-el-siglo-xxi-el-podcast/parir-siglo-21-capitulo-5-ponerle-nombre/6538419/.

354 Barret Cooperativa 2022).

355 Fernández Guillén (2020).

356 UN (2019).

357 UN 2019).

358 Ministerio de Sanidad (2012).

359 Ministerio de Sanidad (2021).

360 Ministerio de Sanidad (2012).

The 'husband's stitch': Some women **have claimed to be victims of** a suture procedure after episiotomy (El País 2018). This procedure of unknown prevalence, which applies **more stitches than necessary**, is carried out, supposedly, for the sexual satisfaction of the husband. Overstitching the vaginal opening after birth, closing it with one or two extra stitches to narrow it to, supposedly, give the husband more pleasure is a strongly harmful patriarchal practice. It is not an express request of the woman or her partner, but an initiative of the practitioners themselves. It is usually made without knowledge of the woman.[361]

Caesarean section abuse: When medically justified, caesarean sections are effective in preventing both maternal and perinatal morbidity and mortality. However, like any other major surgical operation, it is associated with certain short- and long-term risks, such as a higher prevalence of maternal mortality and morbidity or an increased risk of uterine rupture, ectopic pregnancy, stillbirth and premature delivery in subsequent pregnancies. Short-term risks for newborns delivered by caesarean section include impaired immune development, an increased likelihood of allergy, atopy and asthma, as well as increased respiratory problems and obesity. WHO concluded in its 2018 Statement that, at the population level, caesarean section rates greater than 10 % are not associated with a reduction in maternal and neonatal mortality rates and that, ideally, caesarean sections should be performed only when medically necessary.[362] However, as shown, in Spain **there are regions exceeding the 30 % rate**. There are also **hospitals where rates are 50 % or more**.

Unnecessary vaginal exams: Vaginal exams consist of inserting the finger(s) of one hand into the pregnant woman's vagina to measure the parameters of the dilation phase. Vaginal exams are intrusive and painful for the woman and can carry germs from the outside environment into the cervix, where they can cause greater damage. The recommendations of the Ministry of Health are to limit the number of vaginal examinations to the essential minimum, advising not to perform more than one every three hours, unless necessary. Instead, there exists an **abuse of vaginal examinations**. Its prevalence is unknown, although evident through women testimonies. According to WHO, excessive vaginal examinations are a direct cause of possible infections[363] that may affect the newborn ending up with an admission in a neonatal unit, as may have been the case of *S.F.M. v. Spain*, the first case of obstetric violence confirmed by the CEDAW Committee.[364]

Unnecessary use of instruments such as forceps or suction cups: Forceps are an obstetric instrument in the form of pliers, which, inserted into the woman's vagina, normally after an episiotomy, serve to help foetal extraction from the outside. Its use increases the performance of episiotomies and the risk of perineal trauma with long-term sequelae and can therefore condition the development of the sexual life of the women in whom it is practised. As shown in the previous table, in Spain, the percentage of instrumental deliveries over the total of vaginal births (around 19% in recent years) is above the recommended standard (<15% of total vaginal births) – **in 2019, Spain was the country that performed the most instrumental deliveries in Europe**.[365]

361 El País (2018).
362 WHO (2018b).
363 WHO (2014b).
364 CEDAW 2020).
365 Euro-Peristat (2018, 2022).

Use of haloperidol during birth: The administration of haloperidol, a powerful antipsychotic to a parturient is an obsolete, dangerous practice, with no scientific support. Although said to be given as an antiemetic, **in Spain, it is actually used as a sedative** and it can be considered a form of chemical submission.[366] Its prevalence is unknown but its use is evidenced through women's testimonies.[367] The Spanish organisation, Childbirth is Ours, has launched the campaign, *Haloperidol in Childbirth Never Again* to denounce and eradicate this practice.[368] Recently, the High Court of Justice of the Valencian Community has affirmed in a judgment that women can be drugged with haloperidol in childbirth without their permission, in yet another example of how gender stereotypes in clinical settings are reproduced in the judicial sphere, in disregard of the *Law of Patient Autonomy*.

Kristeller manoeuvre: The Kristeller manoeuvre is pressure on the uterine fundus to increase abdominal pressure during delivery, either with one hand, two or the forearm, together with the contraction and towards the maternal pelvis, in order to shorten its duration and assist in the delivery of the baby. Although it is contraindicated due to its potential risks by WHO and the Spanish Ministry of Health, **it persists in 26.1 %** of vaginal deliveries in the Spanish NHS.[369] The risks for newborns include, among others, increased likelihood of complications of shoulder dystocia: clavicle fracture, head trauma and sternocleidomastoid muscle tear; Erb's palsy, which results from injury to the nerves in the brachial plexus that control movement of the shoulders, arms and hands; fractured humerus or ribs; hypoxia; internal organ injuries; bruises and increased intracranial pressure; cephalohematoma and intracranial haemorrhages. The risks for the mother include bleeding and bruising, uterine rupture and uterine inversion, which can cause severe bleeding and, in extreme cases, lead to removal of the uterus, increased risk of third- or fourth-degree perineal tears, urogenital prolapse, placental abruption, rib fracture and contusions. Spanish activists have denounced this practice in the campaign, *Stop Kristeller: A Matter of Gravity.*[370]

Separation of mothers and their newborn: As the *Strategy* states, 'during the first two hours after birth, the newborn child is in a state of tranquil alert. This enables early olfactory recognition of the mother, which is very important for establishing a bond and adapting to the post-partum environment. The separation of the mother and child alters this process and reduces the frequency of successful breastfeeding. The skin contact entails other benefits for the newborn – a quicker recovery from stress, the child's glycaemia, acid-base equilibrium and temperature are regulated earlier – and for the mother – reduction of the uterus via secretion of oxytocin. The bond between mother and child increases the duration of maternal breastfeeding and prevents negative emotional reactions'.[371] In Spain, research has found that experiencing skin-to-skin contact protects mothers against post-traumatic stress disorder symptoms one to five years

366 Olza-Fernández (2021).

367 Testimonies available at: https://www.elpartoesnuestro.es/sites/default/files/public/testimonios_madres.pdf

368 Campaign, *Haloperidol in Childbirth Never Again:*

https://www.elpartoesnuestro.es/informacion/campana-haloperidol-en-el-parto-nunca-mas?fbclid=IwAR3nGayGb-yASB1ebpaL7Kg_e93cjzv1v_DK_IopWfLFeSGBy4xF4kbvaJJY.

369 Ministerio de Sanidad (2012).

370 El Parto es Nuestro. Campaign, *Stop Kristeller: A Question of Gravity*: https://www.elpartoesnuestro.es/informacion/campanas/campana-stop-kristeller-cuestion-de-gravedad

371 Ministerio de Sanidad (2007).

following birth.[372] Nevertheless, **mother-newborn separations are relatively frequent** (50% prevalence in 2010) in Spain[373] – where among the strong and unjustified barriers in the way of parents taking care of their newborns, they are probably **the most emotionally painful intervention**. Activists have strongly denounced mother-newborn separations, **whether in the birth room** – through the campaign of Childbirth is Ours, *Never Separate*[374] – **or in the neonatal unit** – with another campaign from the same organisation, *United at NICU: Do Not Separate Us, A Matter of Health.*[375]

Cascade of interventions: In Spain, interventions during childbirth are not usually made alone – one intervention often leads to another and then another, giving rise to a 'cascade of interventions'. For example, women often arrive at the hospital in labour and, without need, synthetic oxytocin is administered to speed up labour. This gives rise to contractions that are worse than physiological ones, which usually requires pain relief, which is usually applied as epidural anaesthesia, which increases difficulty in pushing, which increases the chances of an instrumental delivery, Kristeller, caesarean section or episiotomy, which leads to further possible interventions. In fact, any obstetric intervention can directly or indirectly increase the chances of ending up cutting or damaging a woman's genitalia, affecting her subsequent sexual and reproductive life.

Other interventions: Examples of medical practices that do not follow recommendations based on scientific evidence are the excessive use of oxytocin, the excessive use of amniotomy or rupture of the amniotic sac, forcing the woman to deliver in the lithotomy position, preventing her from moving freely during childbirth, directing her pushes during delivery, forbidding her to drink water and eat, shaving her perineum, applying an enema, tying her arms during the caesarean section, performing the Hamilton manoeuvre[376] without her informed consent, disregarding her privacy, depriving her of the company of her choice, especially during caesarean sections or instrumental deliveries, and poor care in the case of perinatal death.

Other manifestations of obstetric violence

Other forms of obstetric violence in Spain are related to acts of **verbal disrespect or mistreatment** – i.e. **expressions that aim to subjugate the birthing woman; deprive her of her right to decide and autonomy**; infantilise, discredit and ignore her requests and decisions; and undervalue her ability to give birth. Derogatory and out-of-place language reflects the power imbalance between women and health workers and the gender stereotypes that presuppose that women should be obedient, passive, complacent and to not question medical decisions. **These deeply embedded gender stereotypes allow that verbal**

372 Hernández-Martínez et al. (2020).

373 Ministerio de Sanidad (2012).

374 El Parto es Nuestro. Campaign, *Never Separate*:

https://www.elpartoesnuestro.es/informacion/campanas/campana-que-no-os-separen

375 El Parto es Nuestro. Campaign, *United at NICU*: Do Not Separate Us, A Matter of Health:

https://www.elpartoesnuestro.es/informacion/campanas/unidos-en-neonatos-no-nos-separes-es-una-cuestion-de-salud

376 The Hamilton manoeuvre is a method of attempting to trigger labour by separating the membranes of the amniotic sac from the uterus through vaginal exploration.

abuse and sexist comments to women in labour be publicly tolerated. Newspapers speak openly about '*elderly* primiparas', referring **pejoratively** to women who give birth for the first time and are older than a certain age. In an interview, a midwife acknowledged saying to a woman in labour: '*if you don't push, I'll give you a blow that'll make you go through the wall*' among other threats to her.[377]

Research has compiled some of the **expressions used in Spanish delivery rooms which undervalue or diminish the ability of women to give birth**,[378] such as:

- '***To clean the guard***'', used to refer to forcing births with drugs, manoeuvres or surgery so that no woman gives birth at night and interrupts the rest of doctors and midwives on duty, or to leave the guard free for emergencies. This is of special relevance since research has shown that the distribution of unscheduled caesarean sections by time of birth is not uniform. The proportion of women in Spain that deliver via an unplanned caesarean section is higher in the early hours of the night (from 10 pm to 3 am) and much lower during the remaining hours of the night and the rest of the day.[379]
- '***To give birth to the woman'*** or '*to make the woman give birth*', as if the woman did not give birth by herself, but 'birth/it' is done to her.
- '***Teaching forceps***', used to refer to forceps that are performed not out a true indication but to teach its technique to students.

All these expressions account for the passive role and the lack of power expected from women during birth. But the expression '***the husband's stitch***' goes well beyond that, reproducing one of the most rancid sexual stereotypes: that of a sexual duty or service towards men, disregarding women's sexual health. We are aware through testimonies that '*the husband's stitch*', or '*the husband's suture*', has happened in Spain, as it can be read in **Testimony 5** in Annex 2, retrieved from El País (2018).

The 2020 CEDAW Committee's decision on obstetric violence[380] contains a clear allusion to **out-of-place language** as in the supposed annoyance of mothers who want to breastfeed their newborns: 'the baby was bottle-fed without the permission of the mother, who wanted to breastfeed her daughter but was not allowed to do so because "*mothers ringing the bell are a nuisance*".' Also, the subsequent 2022 CEDAW Committee's decision on obstetric violence[381] takes account of several expressions that were used to **infantilise** the claimant, when she was forced to undergo a caesarean section (see **Testimony 6 in Annex 2**), with phrases such as: '*caesarean yes or yes, and that's it*', or '*calm down, kid, that's it'.*

These expressions and situations reflect an **unbalanced power situation** and **disrespect for women's rights to integrity, decision, autonomy and sexual or reproductive health**.

377 La Voz de Galicia (2010).

378 Fernández Guillén (2015).

379 Costa-Ramón et al. (2018).

380 CEDAW 2020

381 CEDAW (2022).

5.4 Root causes

Understanding how health systems constraints, gender stereotypes and power dynamics favour the violation of human rights during childbirth in the case of Spain is necessary to decide which recommendations and innovative practices to promote. Regarding health systems conditions and constraints, a crucial issue is the **paradigm of technological childbirth,** that is, a **series of beliefs, attitudes and practices in which professionals have been educated** – **and are assumed by society** – **which maintains that by default intervention-assisted births are better.** This paradigm makes health providers carry out unnecessary and harmful interventions, which alter the evolution of many births, creating a series of problems and complications that then must be resolved with more interventions, usually caesarean sections or instrumental births.[382] Thus, it is not the interventions that should be questioned, but their inadequate use or abuse and how scientific evidence is integrated in medical decisions.

When analysing structural root causes in Spain, one should **distinguish between public and private healthcare**. Especially in the private sector, the **advantage of planning daytime births** v unplanned vaginal deliveries of varying duration and **financial incentives** for doctors and hospitals[383] influence the decision-making process of health providers. Births during weekends and holidays are becoming less and less frequent in Spain.[384] Overmedicalisation in private healthcare is also well known.[385] Nevertheless, the ***Strategy* directly excluded private hospitals** from its scope while, paradoxically, private hospitals are the ones that most need to adapt practices to scientific evidence. With regard to public hospitals, the systematic and stable differences in childbirth care indicators between the 17 Autonomous Communities, who under the Spanish system are responsible for territorial planning and the provision of health services, show that **different health policies and organisational forms drive different results** (with caesarean rates ranging from 15% to 32% across regions).

Another crucial issue is that **the mechanism of coordination** that should ensure that the recommendations of the Strategy are transmitted to the Autonomous Communities and from there to **practice in the hospitals through updating protocols and staff training does not work correctly**. Thus, five years after the approval of the Strategy, only 15.5 % of the NHS hospitals had incorporated all the main recommendations for birth into their protocols. This highlights the need to **update care protocols according to *Strategy* recommendations**, but also shows that positive changes **depend basically on the interest of the professionals of the hospital** and above all, of the **people responsible for the service**.[386] The Ministry of Health explicitly considered the **lack of knowledge or updating of health providers** about the evidence-based recommendations of the Strategy among the causes of the low level of compliance with care indicators.

A very important fact is that the **normalisation of obstetric violence increases according to the student's year of study**, i.e. a lower perception of obstetric violence is found among more advanced students, thus being essential

382 El Diario (2022a).

383 Visser et al. (2018).

384 Recio Alcaide & Müller (2016).

385 Recio Alcaide (2015).

386 Ministerio de Sanidad (2012).

to **change the training of health personnel** and continue their **solid foundation in ethics, gender and human rights**.[387] The training of health personnel should take in account that there is a **higher perception of obstetric violence among Spanish female health professionals**[388] and that, while the proportion of women in obstetrics and gynaecology is higher than men, **gynaecology and obstetrics services continue to be led mostly by men**.[389]

Other structural problems are the **low ratio of midwives**[390] and their **insufficient autonomy** to attend births. Optimal staff conditions would ensure that **lack of time, staff**, **funding**, **infrastructure or resources, shift changes, night shifts, weekends and vacation days** do not play a key role in the excess of inductions or caesarean sections.[391] The fact that in Spain there are hardly any **alternatives to medicalised birth in a hospital**, such as **midwife-led birthing centres for low-risk births or home birth within the NHS**, **favours the model of birth with non-evidence-based interventions**.

Gender stereotypes are active in Spain, as in the rest of EU countries, and reinforce the belief that **women are inferior to men and their roles in society are different**. Even if most gynaecology and obstetrics professionals in hospitals in Spain are women (70%), 100% of parturient are women and gender stereotypes of submissiveness are projected onto them, not onto medical services personnel, mostly led by men. Regarding pregnancy and birth, **gender stereotypes emerge** when the **correct behaviour** of women is equated to leaving everything to the doctor's judgement or when women are judged or told off for making decisions, e.g. not getting an epidural.[392] It is **not well seen that a woman screams in labour instead of being calm**, that she lets herself be carried away by her body, or that she decides or **questions medical practices**. Women are very frequently **treated as inferior** in health settings and they are **infantilised** – being **addressed with a familiarity that they have not requested** is commonplace.

In the case of *S.F.M. v. Spain*,[393] the Committee observed that the administrative and judicial authorities of Spain employed stereotypical and thus discriminatory notions by **assuming that it is for the doctor to decide whether or not to perform an episiotomy**, stating without explanation that it was 'perfectly understandable' that the father was not allowed to be present during the instrumental delivery and taking the view that the psychological harm suffered by the complainant was a matter of **'mere perception'** – but that they did show **empathy towards the father** when he stated that **he had been deprived of sexual relations for two years**. In the case of *N.A.E. v. Spain*,[394] the Committee observed again that the administrative and judicial authorities of the State party applied stereotyped notions and, therefore, were discriminatory, **assuming, for example, that it is the doctor who decides whether or not to perform the caesarean section** without duly analysing the various evidence and reports provided by the complainant that precisely indicated that a caesarean section was not the only alternative, or by assuming that the psychological injuries suffered

387 Mena-Tudela et al. (2020).

388 Mena-Tudela et al. (2020).

389 El Parto es Nuestro (2022c).

390 Diario Médico (2022); El Diario (2022b); El Periódico de Aquí (2022).

391 Recio Alcaide & Müller (2016); Costa-Ramón et al. (2018).

392 UNED (2015).

393 CEDAW (2020).

394 CEDAW (2022).

by the complainant were a matter of **mere perception**.

In general, there is a **lack of awareness that women's decisions must be respected** even if they go against medical criteria. **Gender stereotypes impede seeing that the *Law 41/2002 of Patient Autonomy* also applies to women in labour**. Health professionals acknowledge **patriarchal system as an underlying factor of obstetric violence**.[395] The sexism of the Spanish Society of Obstetricians and Gynaecologists (SEGO) was denounced by activists when the cartoons of the SEGO electronic gazette offered a **degrading image of Spanish women**[396] and the complaint had a huge impact in the media.[397]

When analysing midwives' experiences regarding obstetric violence in Spain, most claimed to have **witnessed obstetric violence** and to have been **trained to practise it**. The experiences described by staff were clear examples of **institutionalised violence against women giving birth and their babies**. Among the sentences that midwives used to describe obstetric violence are[398]: *'to prepare a woman for c-section, without more indication that the interest is finishing before dinner time';* or *'**do not explain it to the women ... the less they know the better**';* or *'**they teach us** that we have **to protect each other**, if we witness any violence we always excuse ourselves by saying that what happened is right, **we never say the truth to women** or support them';* or *'denying women water or being able to stand and walk during labour';* or *'doing an episiotomy without being indicated';* or *'I saw **a woman's mouth being covered so that she could not scream**' ;* or *'**accusing the woman** of not wanting to give birth'.*

The dynamics of power between health centres and patients are another cause of abuse and violence, aggravated by gender stereotypes about the role of women in society. As the UN Rapporteur highlights[399]: '**the health provider has the power of authoritative medical knowledge and the social privilege of medical authority**, while the woman is largely dependent on the provider for information and care. A **woman during childbirth is also particularly vulnerable**. Although providers do not necessarily have the intention of treating their patients badly, 'medical authority can thus foster **a culture of impunity**, when human rights violations do not only go unremedied, but unnoticed. **This power imbalance is particularly apparent in instances in which providers abuse the doctrine of medical necessity** in order to justify mistreatment and abuse during childbirth'. In Spain, these power dynamics are heavily established. None of the narratives and situations detailed here reflect a balanced power situation between patients and health staff. Unnecessary interventionism, to improve the comfort of health staff to the detriment of the good progress of delivery, does not reflect a balanced power situation either.

395 Mena-Tudela et al. (2022).

396 El Parto es Nuestro (2011°).

397 El Parto es Nuestro (2011b).

398 Olza-Fernández & Ruiz-Berdún (2014).

399 UN (2019).

5.5 Consequences

The use and abuse of non-evidence-based clinical practices and the violation of the right to integrity and autonomy during childbirth have long-lasting consequences **on women's sexual, reproductive and emotional/mental health, but also on the health of their newborns and on professionals**. General adverse effects are a **higher prevalence of maternal and newborn mortality and morbidity** while effects have been **described in detail for each concrete clinical practice** in section 5.3.2. Childbirth can be **a traumatic event** for many women which can take **years to recover** from and different studies have found a **high prevalence of trauma symptoms following childbirth**.[400]

The **health providers** who work in pregnancy and birth care **may also suffer this violence**, **feeling like accomplices in participating in it, and being traumatised after witnessing abusive and/or violent practices in a moment of maximum vulnerability for the parturient**. Naturally, **it can be difficult for professionals to accept** that they have received professional training and have been socialised in a **paradigm based on the superiority of technological and intervened childbirth**.[401] Research has studied the consequences of obstetric violence for healthcare professionals who have participated in birthing processes in Spain, in a survey on their opinion of obstetric violence.[402] To the question of **giving examples of obstetric violence that they had experienced**, their literal answers were very diverse, e.g.: (1) *'they taught me to pull the baby's head, the systematic use of episiotomy, oxytocin, shaving of the pubis and enemas – against my better judgement and against the desires of the woman';* (2) *'when a woman is sedated so that she remains quiet and compliant and doesn't bother to healthcare professionals'; (3) 'when a student performs an unnecessary instrumental vaginal delivery only to learn the technique'; or (4) 'when someone shouts that the woman isn't doing it right and that she is going to kill her baby'.*

Obstetric violence also produces changes in some areas which affect the lives of healthcare staff. In some cases, they **distrust other personnel** when they diagnose and suggest treatment. **Some of them abandon their jobs in hospitals** to devote themselves to assist births at home. Others remain in their jobs, but suffer serious consequences, such as **burnout or other psychological problems**: *'I fight for women's rights, but nobody is fighting for me. My ethics, my principles don't pay the bills. I give up'.* The personal cost for sensitised staff is high. Many had to leave or change workplaces or even professions and **suffered from secondary post-traumatic stress disorder**.[403] The **cost of obstetric violence for themselves** was described with sentences like:

> *(1) 'It forced me to leave the hospital. I changed hospitals several times'; (2) 'I had to leave and start attending home births'; (3) 'I suffered burnout and mobbing. I stopped attending births'; (4) 'I have had symptoms of depression and I've been crying remembering the delivery room, traumatised. A gynaecologist hit me once when I was gently and politely touching his arm to ask him to stop making a brutal Kristeller manoeuvre to a young woman in labour. The girl asked to stop and it continued and continued. It seemed like a rape. I still want to cry and have nightmares'; (5) 'many times, I went home crying and had nightmares related to past births. And above all I have*

400 Olza-Fernández (2013).

401 Wagner (2001).

402 Ruiz-Berdún & Olza-Fernández (2016).

403 Olza-Fernández & Ruiz-Berdún (2014).

> *felt deep guilt for having been accomplice to such violence'; or (6) 'I have come to think that many of the complications that arise are our fault. And I know that I am right because the vast majority of births are complicated by the unnecessary work'.*

As these words show, health professionals can also suffer obstetric violence as well as its aftermath, e.g., **long-lasting emotional distress or effects in their professional career and personal lives**.

Other consequences of obstetric violence include a **strengthening of gender stereotypes and inequality**, on which discriminatory attitudes are based. When women's right to decide is stolen and their right to autonomy is disrespected, **sexist stereotypes about the passive and submissive role of women** in society **are reaffirmed**. Each childbirth in which the woman's right to autonomy is ignored **feeds existing biases instead of confronting them**, contributing to **normalising the mistreatment and discrimination, not only in the field of medicine.** This is manifested, for example, in the inability of the Spanish justice system to prevent and defend women from violence and discrimination against them. It is the case of *S.F.M. v. Spain*,[404] where the CEDAW Committee considered that '**stereotyping affects the right of women to be protected against gender-based violence, in this case obstetric violence** and that the authorities responsible for analysing responsibility for such acts should **exercise particular caution in order not to reproduce stereotypes**. It is also the case of *N.A.E. v. Spain*,[405] which had also to be taken to the CEDAW Committee, after appeals to the Constitutional Court in Spain and to the European Court of Human Rights were dismissed. As WHO also acknowledged in its *Announcement* on World Patient Safety Day 2021,[406] 'since maternity care is affected by issues of equality and gender violence, the **experiences of women during childbirth can empower or inflict emotional harm and trauma**'.

5.6 Obstetric violence and Covid-19

The **setback experienced in women's rights during the Covid-19 pandemic** deserves a separate mention. On 13 March 2020, WHO published recommendations on childbirth care, post-partum and lactation regarding the coronavirus disease[407] that have not yet changed.[408] In them, WHO indicated that all pregnant and post-partum women and their newborns – including those with confirmed or suspected Covid-19 infections – have the right to high-quality care before, during and after childbirth, including mental healthcare. The recommendations emphasise that a safe and positive childbirth experience includes: **being treated with respect and dignity**, having a **companion of choice** during delivery, developing **clear communication** with maternity staff, accessing **appropriate pain relief** strategies, engaging in **mobility during labour** where possible and adopting the **birth position of choice**.

404 CEDAW (2020).

405 CEDAW (2022).

406 WHO (2021).

407 WHO (2020).

408 Coronavirus disease (COVID-19): Pregnancy, childbirth and the postnatal period: https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-pregnancy-and-childbirth#:~:text=What %20care %20should %20be %20available,childbirth %2C %20including %20mental %20health %20care.

If Covid-19 is suspected or confirmed, health workers should take all appropriate precautions to reduce risks of infection to themselves and others, including hand hygiene and appropriate use of protective clothing like gloves, gown and medical mask. When asked if pregnant women with suspected or confirmed Covid-19 need to give birth by caesarean section, WHO clarifies that **WHO advice is that caesarean sections should only be performed when medically justified** and that the mode of birth should be individualised and based on the woman's preferences, alongside obstetric indications. When asked if a woman with suspected or confirmed Covid-19 can touch and hold her newborn baby, WHO advice is affirmative: **close contact as well as early and exclusive breastfeeding** helps a baby to thrive. The mother should be supported to breastfeed safely, with good respiratory hygiene, hold her newborn **skin-to-skin** and **share a room with her baby**.

Nevertheless, Spanish activists have denounced that during the Covid-19 pandemic there has been **an increased loss of control by women in their reproductive processes and rights** by violating the right to their autonomy, their integrity and their capacity to make informed decisions about their reproductive health.[409] Indeed, *Childbirth is Ours* has denounced that, during many months of the pandemic, the association received a **great number of complaints and concerns** not only **from women, but also from health staff, mostly midwives,** about the violation of the rights of women and newborn that occurred during childbirth as a result of the pandemic.[410] The most frequent complaints had to do with: (a) The **violation of the right of women to be accompanied** during childbirth by a person of their choice, both in Covid-19 positive and PCR negative women, against WHO recommendations; (b) The **violation of the right of women not to be separated from their newborn** without a medical indication that supported it, alluding to logistical reasons. In many Spanish hospitals, a protocol for the separation of infants of asymptomatic mothers with positive PCR or pending confirmation was imposed, against WHO recommendations; (c) The **obligation to give birth with a mask**; (d) **Having been subject to induced labour protocols and even caesarean section**, if suspected Covid-19, against the WHO recommendations; and e) **Having been subject to interventions aimed at accelerating and shortening the time delivery**, such as the use of oxytocin or instrumentalisation of childbirth, against WHO recommendations. Research has also described the impact of the pandemic on new and expectant parents in Spain, showing that the main issues for them were the **limited access of partners to antenatal care services and mother–newborn separation**.[411]

409 El Parto es Nuestro (2021).

410 El Parto es Nuestro (2021).

411 Colaceci et al. (2022); Vila-Candel et al. (2022).

5.7 Achievements and challenges

There is an evident **lack of official information** on obstetric violence. Although the CEDA Committee in 2020 specifically urged Spain to conduct research into obstetric violence,[412] no official reports, studies, surveys or statistics have been launched so far. **No official information exists on the violation of the right to autonomy of women giving birth** and, although aggregated information regarding perinatal indicators is available, **information is scarce at the hospital level**, especially in the private sector. This prevents women from making informed decisions on where to give birth, based on objective **information that is collected by official statistics and exists but is not made public**. The supervision of hospital centres and the **annual compilation and publication of data by hospital, both for public and private hospitals,** on the percentage of caesarean sections, inductions, episiotomies and other reproductive health indicators, **easily accessible to users**, is a long-held request of Spanish activism, but has not yet been granted. It is also a **widely indicated recommendation by national and international organisations**, such as the UN,[413] the Spanish Ministry of Health (Ministerio de Sanidad 2012), the Council of Europe in its the *Resolution on Obstetric and gynaecological violence*, the CEDAW Committee,[414] WHO[415] and the general recommendation on the public availability at the hospital level of indicators of delivery care, made in the WHO Statement, 'Appropriate Technology for Birth'.[416]

5.8 Relevant initiatives and their impact

5.8.1 Initiatives leading to political action

Relevance of the topic in political and institutional debate

Spanish activists have been denouncing obstetric violence for years. However, politicians and institutions have only focused on childbirth care, which caused the approval of the *Strategy* in 2007 without a human rights violation approach. It has been **in the last four years** when, together with the fourth feminist wave and the recognition by international institutions of the phenomenon, **obstetric violence has begun to gain relevance in political and institutional debate**. The first sentence of the CEDAW on obstetric violence – Spain being the state party – was known at the end of February 2020 and, also in 2020, the term 'obstetric violence' was included in the *Law* 17/2020 of Catalonia and debated within the Ministry of Equality at the request of *Childbirth is Ours*. The debate at the political and institutional level has become manifest on several occasions. The pressure exerted by medical colleagues and colleges who reject the term has had an effect – with the final non-inclusion of the term obstetric violence in the Valencian Law, in the Law of La Rioja and in the Reform of the *Sexual and Reproductive Health Law* of the national legislation. However, the term was included in March 2022 in the Basque Country legislation.

412 CEDAW (2020).
413 UN (2019).
414 CEDAW (2020).
415 WHO (2014a).
416 WHO, (1985).

In raising awareness, the birth rights movement has been pivotal in the 2020s, when requesting the Ministry of Equality to include the term in national legislation both formally – through allegations – and informally – through campaigns on social networks. Along with these actions, the **complaints and tenacity of the victims and their lawyers** were decisive – after receiving refusals from the Spanish judicial system, they took their cases to the UN, working and waiting for years to obtain recognition of the violence to which they had been subjected. Recognition of the topic by some healthcare providers also played a major role.

Degree of recognition of the topic by healthcare providers

There exists a strong **resistance and denial of some health practitioners and professional bodies.** The General Council of Official Colleges of Physicians (CGCOM) and the Spanish Society of Gynaecology and Obstetrics (SEGO) reacted to the announcement of the inclusion of obstetric violence in national legislation asserting that the **term is offensive**, does **not conform to reality** and **criminalises professionals**. In their statements, they emphasise that they adhere to the position issued by the scientific community' and guarantee the absence of violent acts in patient care. They recall the commitment of the specialists in gynaecology and obstetrics to ensure the wellbeing of women. The use of the term 'violence', they argue, is offensive since obstetric procedures that may be considered excessive and inappropriate would, in any case, be actions based on the principle of beneficence, **seeking the best for women**. They further state that the medical profession asks for caution and not to create unnecessary social alarms that can contribute to deteriorating the **necessary trust** between the doctor and his patient; rigour to denominate professional practices and respect for specialists who work with dedication, service, humanity and ethics.[417]

Other professional bodies, such as the Federation of Associations of Midwives of Spain,[418] argue that obstetric violence is exercised against the human rights of women because they are women (that is why it is gender violence) and goes against their dignity and integrity, with the aggravating factor of the special vulnerability that occurs in the circumstances surrounding reproduction. Obstetric violence not only harms women, it also degrades the professionals who carry it out and goes against their own ethics and dignity. They also said that **nobody can say that they are not aware of the existence of obstetric violence in the public and private health systems in Spain**.

The Catalan Society of Obstetrics and Gynaecology and the Council of Medical Associations of Catalonia[419] declared that the use of the term 'obstetric violence' **generates rejection** in most health professionals, to the extent that it suggests intentionality and willingness to exercise violence against women. Professionals perceive that **their professionalism is questioned** when the goal of every professional is to ensure the health and wellbeing of the people it assists. Nevertheless, the SCOG also declared that, despite the discomfort that the term obstetric violence may generate, it has been internationally recognised and adopted by the United Nations and by the European Commission, among other organisations and institutions. The Generalitat of Catalonia itself has regulated it and defined its meaning in the Law 17/2020 of Women's Right to Eradicate Sexist Violence. They

417 CGCOM (2021); SEGO (2021).

418 FAME (2022).

419 SCOG (2022).

concluded that **it is appropriate, therefore, to overcome the rejection that the term initially provokes to grasp its real meaning and** be able to **enter into the debate of the substantive issues**.

Finally, **medical, nursing and psychology student associations**[420] reacted with a position statement in which they **request** the updating of both teaching material and protocols, due compliance with international recommendations on the obstetric practices in all state hospitals, development of specific legislation that protect the people present in the obstetric circuit from this type of violence and greater visibility of this problem.

In summary, **women's complaints** over the years through testimonies, campaigns and legal proceedings, together with the recent **recognition of international organisations** and the **self-reflection** of the health providers themselves, support increasing awareness of the problem of obstetric violence among practitioners and staff.

Degree of recognition of the topic by the general public and women, effective measures implemented, how was awareness raised and resistance overcome, role of local social movements and bottom-up approach

Improving childbirth care in Spain has been and is a **collective effort**. Among local associations, movements and networks that have fought for birth rights in Spain are, **for example**: **Dona Llum** [Women Birth], **El Parto es Nuestro** [Childbirth is Ours], **Iniciativa para la Humanización de la Asistencia al Nacimiento y la Lactancia** [Initiative for Humanisation of Birth and Breastfeeding Care], **Naixença** [Birth], **Observatorio de Violencia Obstétrica** [Observatory of Obstetric Violence], **Parir en Libertad** [Give Birth in Freedom], **Plataforma Pro Derechos del Nacimiento** [Pro Birth Rights Platform], **Umamanita** [Perinatal and Neonatal Death Support], and **Vía Láctea** [Milky Way], among others. **Together with** decision-making professionals, policymakers, institutions and health centres – **teams and individuals belonging to different civil or civic spheres – they have all contributed to raise recognition of** the topic **of obstetric violence**.

Detailing the contribution of so many participants is beyond the scope and length of this report. But **Annex 1 offers a description of how** one of those **grassroots associations – El Parto es Nuestro [Childbirth is Ours]** – **contributed to the reform of the birth care system in Spain. Its bottom-up approach is paradigmatic on how women's movements have raised awareness and overcome resistance in Spain.**[421]

Contacts between associations and public institutions have continued through the years, regardless of the type of national or regional governments. But **it has been during the current legislature (from 2019 up to now), thanks to all birth rights activism and increasing awareness of the Ministry of Equality, that obstetric violence was definitely positioned at the national political and institutional level**, forcing all stakeholders to make their views known and giving obstetric violence **unprecedented visibility in the media**.

420 AEEE et al. (2021).

421 Villarmea et al. (2016).

5.8.2 Initiatives to combat obstetric violence

Relevant initiatives

In addition to the **initiatives put in place by birth activism** described previously, obstetric violence – or some of its manifestations, especially overmedicalisation – has been addressed in the ***Strategy for Normal Birth Care*** **of the Ministry of Health**, in the cited **regional legislation of Catalonia and the Basque Country** – which name obstetric violence as one more type of violence against women – and **in the Reform of the *Law 2/2010***, which – without naming the term – deals with several of its manifestations and provides solutions to some problems encountered by the Strategy.

As revealed, the *Strategy* has only been effective to a certain extent. **Among its barriers is the fact that it is voluntary** and that its implementation remains subject to the will of health advisers, hospital managers and service heads. Providing a solution to this problem is the goal of the **common protocol of actions reflected in the Reform** of *Law 2/2010*, but its effectiveness remains to be seen. Besides, the inclusion of the term in regional legislation, by itself, cannot correct the problem effectively. **Recognition in the law must be accompanied by effective measures** that address the structural causes of the phenomenon.

There are **no institutional initiatives or support to denounce obstetric violence** except the **legal and financial support** – sometimes via crowdfunding – **offered by activism**. **Denouncing cases of obstetric violence is a long and tortuous road for victims and their lawyers** since, as the CEDAW Committee states, they face gender stereotypes in the very judicial processes that are supposed to protect their rights.[422] It is also worth emphasising that **the views of the CEDAW Committee have so far been ignored by Spanish institutions and the victims have not yet been compensated**.

Initiatives to involve and train professionals in recognising, understanding and preventing obstetric violence

One of the strategic lines of the *Strategy* is to promote the specialisation and **continuous training of professionals.** To this end, the *Strategy* recommendations are: (a) **To train in knowledge and skills** of medical and nursing staff, both during early education and development of a professional career; (b) To facilitate the **training of trainers**; (c) To train health personnel to improve **communication with women and share decisions and responsibilities;** and (d) To include equity aspects in training activities, **taking in account the gender perspective**, with special emphasis on the empowerment of women, multiculturalism and diversity. At this point, a **wide variability was observed between Autonomous Communities**, both **in the number of courses that have been organised and attendees**. Regarding the professional profile of the attendees, **midwives attend in greater numbers (40 %)**, followed by paediatricians (19 %), nurses (14 %), **obstetricians (13 %)**, family doctors (8 %) and other professionals 6 % (physiotherapists, social workers and lactation monitors). The over-representation of midwifes shows the need to **guarantee that continuing education reaches all personnel uniformly** in a **coordinated** manner.

422 CEDAW (2020); CEDAW (2022); Fernández Guillén (2022).

The CEDAW Committee has recommended that Spain provide obstetricians and other health workers with adequate professional training on women's reproductive health rights and to provide **training to judicial and law enforcement personnel**.[423] In this sense, the **Reform of the *National Organic Law 2/2010 of Sexual and Reproductive Health and of the Voluntary Interruption of Pregnancy*** considers in Article 29 the training of the personnel of the gynaecology and obstetrics services for the respect and guarantee of women's rights. It has recently been shown that educational interventions remain an effective way to **change health sciences students' perception of obstetric violence**.[424] In the meantime, some **training on obstetric violence for professionals** and university students is in place.[425]

Initiatives to support women in the exercise of their reproductive rights, especially the right to enjoy a positive, respectful and free-of-harm birth experience and to support victims of obstetric violence

Initiatives to support women in the exercise of their reproductive rights are found in the *Strategy*, the Reform of the *National Organic Law 2/2010* and birth rights activism.

The chapter on the '***Protection and guarantee of sexual and reproductive rights in the gynaecological and obstetric field***' of the **Reform of the *National Organic Law 2/2010*** is intended to guarantee women the exercise of their reproductive rights, especially the right to enjoy a positive, respectful and harm-free childbirth experience, since it recognises in Article 27 the right to **mandatorily require the free, prior and informed consent** of women in all invasive treatments during delivery care; to **reduce interventionism, avoiding unnecessary and inappropriate practices** that are **not supported by scientific evidence;** to provide **respectful treatment** and clear and sufficient information; and to guarantee the **non-separation of newborns from their mothers and other people with a direct link** to them.

Regarding **initiatives to support victims**, it is the very **health institution**, whether public or private, which **paradoxically provides the applicable** – and **limited** – **health services to overcome the consequences of** the **institutional violence** of obstetric violence. In addition, the Preliminary Draft foresees **advice to women about their rights** and the **provision of channels for claims that may be made by those who have been affected** by conduct contrary to those established in the respective Chapter. This support can be **not only psychological, but also legal.** Currently, victims basically only receive the **support of women's associations committed to rights during childbirth**.

423 CEDAW (2020).

424 Mena-Tudela et al. (2020).

425 El Parto es Nuestro & Lo Cascio (2021).

Initiatives to deconstruct general assumptions on childbirth, (over)medicalisation of reproductive health, gender and other stereotypes, naturalised behaviours, beliefs, practices or power dynamics

Under the umbrella of the *Strategy*, a series of guidelines were published, with recommendations based on the available scientific evidence: ***Clinical Practice Guideline on Care for Normal Childbirth***,[426] *Clinical Practice* ***Guideline on Breastfeeding***,[427] *Clinical Practice* ***Guideline on Care during Pregnancy and Puerperium***[428] and ***Neonatal Care Guideline***,[429] as well as the ***National Strategy for Sexual and Reproductive Health***.[430] They all contributed to deconstructing general assumptions on childbirth and reducing overmedicalisation.

The Reform of the *National Organic Law 2/2010* foresees a Common Protocol of Actions to protect sexual and reproductive rights in the gynaecological and obstetric field, which will include the necessary measures so that the health sector contributes to guaranteeing sexual and reproductive rights in this area. Above all, a huge effort has been made by **CSOs** to deconstruct general assumptions on childbirth, the overmedicalisation of reproductive health, gender and other stereotypes, beliefs, practices and power dynamics. A good example can be found in the peer and support groups organised by Childbirth is Ours – online and in person – where **women support each other and exchange information** and in the numerous **campaigns** carried out by the organisation.

5.9 Conclusions and recommendations

Clinical practice regarding birth care in Spain continues to be **excessively interventionist**. Despite recent **health policy efforts**, there is much room for clinical practices being aligned to standards and recommendations, thus being evidence- and values-based. **Childbirth, a physiological process** that should be treated as such, is frequently full of **interventions with no medical justification** from the moment the woman enters a hospital. **Private healthcare** especially stands out for its unwarranted interventionism, although overmedicalisation is widespread in the public system too. **Women and newborns** – **but also health staff** – **suffer** overmedicalisation directly on their bodies, minds and lives, with **physical, mental and other consequences in the short and long run**. Moreover, many of the excessive or routine interventions are **performed without the woman's informed consent or even with its explicit denial** – this constitutes a forced intervention, thus **violating her human right to integrity and to decide on her body and reproductive processes**. Ignoring autonomy and violating physical integrity constitute abuse and mistreatment, that is often **accompanied by degrading and humiliating comments** which further strip women of their decision-making power.

The **ideal of technological childbirth, gender stereotypes**, **organisational factors**, **working conditions** of health professionals and **medical power over patients** are **structural causes** behind mistreatment during childbirth care. The **internationally accepted notion** of describing this structural 'mistreatment' during childbirth, pregnancy and post-partum care is **obstetric violence**. Despite some recent efforts to legally recognise the existence of obstetric violence

426 Ministerio de Sanidad (2010b).

427 Ministerio de Sanidad (2017).

428 Ministerio de Sanidad (2014).

429 Ministerio de Sanidad (2010°).

430 Ministerio de Sanidad (2011).

in Spain, either regionally or nationally, **medical colleges' pressure** on regional and national governments has had an effect, **dissuading some of the initial intentions to legally recognise it and protect women from this type of violence**. However, **professional awareness on the issue is high**. Spanish **civil society and women's complaints** have played **a crucial role in raising awareness** on the subject, with an **impact on public health policies**. But it has been in recent years, with the **fourth feminist wave** and the **recognition by international institutions** of the phenomenon – including two sentences of the CEDAW Committee on obstetric violence in which the State party is Spain – that obstetric violence has begun to gain relevance in political and institutional debates as **a human rights issue**.

There is a need to accompany the institutional recognition of obstetric violence with effective measures, **sufficient guarantees** and **coordination** to address its causes, to **change the paradigm of medicalised birth** with staff training and updating and to **ensure that the *Law 41/2002 of Patient Autonomy* applies to pregnant women**. **The Reform of the *National Organic Law 2/2010 of Sexual and Reproductive Health and of the Voluntary Interruption of Pregnancy* was an opportunity not to be missed**.

In the light of the above conclusions, the following concrete recommendations are made for Spain:

Institutional recognition of the occurrence of obstetric violence. Spain should legally recognise the occurrence of obstetric violence and its causes as a widespread and systematic phenomenon and as a form of violence against women. **Recognising the mistreatment that women are subjected to during childbirth and its structural causes helps to increase awareness and to address its driving factors**. The adoption of legislative and policy measures to address violence against women during reproductive health services has already been addressed by the UN (2019). **Admitting the existence of obstetric violence means recognising the gravity of the testimonies of women**.

Allocation of sufficient funds for staff, equipment, training, birth care and improvement. Women's right to achieve the highest level of sexual and reproductive health is recognised in Article 95 of the Beijing Declaration (UN 1995), of which Spain is a signatory. To meet this obligation, Spain must devote the necessary available resources to sexual and reproductive health as well as adopt a human rights–based approach to determining needs and budget allocations. Staff conditions should be optimal: **organisational and logistical changes should be made** to ensure that **lack of time, staff, infrastructure or resources, shift changes, night shifts, weekends and vacation days** do not play a key role in excessive medical interventions.

Guarantee of medical practices supported by scientific evidence and eradication of outdated practices or those based on beliefs and customs. Evaluation and monitoring of indicators on childbirth care in Spain reveal a **lack of adaptation of clinical practice to the standards of and recommendations** by national and international health institutions. The surplus of medical interventions and the unjustified variability across regions and hospitals have been highlighted in different statements and studies. The crisis caused by the Covid-19 pandemic has led to a setback of medical practices without the support of scientific evidence, despite the available specific recommendations from WHO for pregnancy and delivery care during the pandemic. **A mechanism of coordination and control should ensure sufficient guarantee that clinical practices are evidence- and values-based**.

Inclusion of the recommendations of the Strategy for Normal Birth Care and associated guidelines in hospital protocols and regional health plans. The inclusion of the *Strategy* recommendations in hospital protocols offers a guarantee of a clinical practice that is more in line with these recommendations, as its evaluation concluded that **the presence of a complete protocol is related to better compliance with the *Strategy* recommendations** (Ministerio de Sanidad 2012). However, five years after the approval of the document, only 15.5 % of the NHS hospitals had incorporated all the main recommendations for birth into their protocols. The level of adherence to the *Strategy* needs to be raised; leaving it at the level of recommendations has not introduced the expected practical implementation, despite the strong scientific evidence that supports each recommendation. **Protocols and regional health plans should include recommendations listed in the *Strategy* and all its clinical practice guidelines and associated documents**. Updates should include recommendations for high-risk births. **A mechanism should ensure its compulsory inclusion in hospital protocols and regional health plans.**

Extension of the scope of the Strategy to private healthcare. The *Strategy* has meant progress and has had a positive and significant effect on improving childbirth care. Hence, the implementation of its strategic lines and recommendations must be considered a public health issue with no distinction between public or private health. After all, it is in private centres where a greater number of obstetric and medical interventions are carried out without the support of scientific evidence. **The eradication of violence during childbirth requires a cross-cutting approach from which private healthcare cannot be excluded**.

Guarantee of informed consent for women in labour. Spain must, in accordance with United Nations and human rights recommendations: (1) **Guarantee the proper and effective application of the requirement to obtain informed consent in accordance with human rights standards**; (2) Adopt laws and policies on health that are **effective for the application of the requirement of obtaining informed consent** in all reproductive health services. Policies should be along the lines of guaranteeing rights that are already covered by the law, for example with adequate monitoring of practices around informed consent in hospitals and correction where necessary; and (3) **Respect women´s rights to integrity and autonomy to make informed decisions** about their reproductive health.

Transparency, improvement of the evaluation of birth care, and publication of the main indicators by hospital. There is a lack of transparency regarding birth care information at the hospital level, especially in the private sector, that prevents citizens from making informed decisions based on objective information that should be public. The supervision of hospital centres and the **annual compilation and publication of data by hospital, both for public and private hospitals,** on the percentage of caesarean sections, vaginal deliveries, episiotomies and other reproductive health indicators is essential. Its results by hospital must be **public and easily accessible to users** of reproductive health services, as recommended widely by international institutions. Carrying out **studies on obstetric violence that highlight the prevalence of the situation and orientate public policies** to fight such violence is indispensable, as pointed out by the CEDAW Committee.[431]

431 CEDAW (2020, 2022).

Greater recognition, number and autonomy of midwives in hospitals, as adequate professionals to attend normal births. One of the key recommendations in the Ministry of Health's *Clinical Practice Guideline on Care for Normal Childbirth* on the profile of professionals is that hospital teams **promote low-risk birth care, preferably by midwives**, as long as birth develops within normal limits. It also recommends that **women in labour be attended individually by a midwife during the whole length of their stay**.[432] To that aim, **the low ratio of midwives** and their **insufficient professional independence** must urgently be addressed.

Training of health professionals and continuous updating of their skills and knowledge in accordance with the available scientific evidence. **Educational programmes** to train and update health professionals on matters of **health, law, gender and relevant disciplines have been found to be critical**. This type of education is included in one of the four strategic lines of the *Strategy;*[433] the development and continuation of such programmes was recommended by the Ministry of Health in the 2012 evaluation.[434]

Training on obstetric violence with a gender and human rights perspective for health and judicial personnel. **Adopting a gender and human rights perspective to train health and judicial personnel on obstetric violence**, and developing awareness-raising actions on its consequences for women, newborns and health providers, is **of utmost importance to address human rights violations against women**, as indicated in the recommendations of international organisations – e.g., UN, Council of Europe and CEDAW Committee.

Adaptation of birth care spaces: guarantee of joint mother-newborn admissions and 24-hour access to neonatal units for mothers and companions. The European Charter for Hospitalised Children, approved by the European Parliament in 1986, expressly includes '**the right of the child to be accompanied by their parents** or the person who replaces them, for as long as possible during their stay in the hospital, not as passive spectators, but as active elements of hospital life'. And yet, the Ministry of Health recognises that '**there are still barriers to family access to neonatal units**. The newborn has the right to receive maternal or paternal care and its development is linked in part to the quality of the future interaction with their family'.[435] The hospitalisation of mothers and their children in individual rooms should be guaranteed and the **neonatal intensive care units should have their doors open 24 hours a day** for the mother and her companion, with care focused on the family and wellbeing, as recommended by the Ministry of Health.[436]

Guarantee options other than hospitals, such as birth centres, run by midwives in the public health system. The fact that there are hardly any **alternatives to medicalised birth in a hospital**, such as **midwife-led birthing centres for low-risk births or home birth within the NHS**, **strengthens the model of highly intervened births.** Options other than hospitals should be available that **citizens can choose within the Spanish public health system**, **the place they prefer to give birth, be it a hospital, a birth centre or their own home**, if safety conditions are met, as recommended by the UN (2019), professionals[437] and experts.[438]

432 Ministerio de Sanidad (2010b).
433 Ministerio de Sanidad (2007).
434 Ministerio de Sanidad (2012).
435 Ministerio de Sanidad (2010a).
436 Ministerio de Sanidad (2010a).
437 FAME (2020).
438 Ruiz-Berdún et al. (2022).

Annex 1 - Evolution of the obstetric violence debate in Spain: the case of Childbirth is Ours

The evolution of the debate on obstetric violence in Spain is the result of a collective action (see above section 5.8.1). Describing the actions of so many participants is beyond the scope and length of this report. But **the report considers it important to offer a description of the actions undertaken by at least** one of those **grassroots associations. The authors have chosen El Parto es Nuestro [Childbirth is Ours] because its bottom-up approach is paradigmatic of how women's movements raise awareness, overcome resistance and contribute to the reform of the birth care system in Spain.**[439]

To **portray the evolution of the debate on obstetric violence in Spain, Annex 1 uses the philosophical Theory of Controversies**[440]– which classifies polemic exchanges or debates into three ideal and technical epistemic types: **discussions, disputes** and **controversies** – to illuminate **how critical rationality and civil action shaped the evolution of the debate on obstetric violence and played a key role in implementing effective measures against it in Spain.**[441]

Phase 1 of the debate: 'discussion'

According to the Theory of Controversies, a debate is in a phase of 'discussion' – in Dascalian terms – when disagreements are considered as experts-only issues. During this first phase of the debate on birth care then, birth care was meant to be discussed exclusively by professionals. As a consequence of this, already in 2002 Spanish obstetricians were being criticised for not allowing women to participate in decisions about their maternity care.[442] To counterbalance the approach where only experts are allowed to be involved, in order to bring the discussion of birth rights to the table and birthing women's voices to be heard, **the association El Parto es Nuestro was founded** on the basis of the previous group Apoyocesáreas [Caesarean Sections Peer Support] by 21 mothers and 1 father in **October 2003**. A transcription of an oral **statement of motivation** by one of its founders on what led **to set up the association** can be read **in Testimony 7 in Annex 2**.

439 Villarmea et al. (2016).

440 Dascal (1998).

441 Villarmea et al. (2016).

442 Johanson et al. (2002).

As described in its bylaws, the **aims** of the association are: (a) to **provide psychological support to women** recovering from caesareans and **traumatic births**; (b) to improve maternal and infant care in Spain, promoting the **respect for the WHO recommendations and human rights** related to reproductive health and the **elimination of discrimination against women**; (c) to **provide information** on physiological, emotional and social aspects of reproductive and perinatal health and care; (d) to **decrease the rate of unnecessary caesareans and traumatic births**; (e) to **recover mothers' and families' role** as leading actors in childbirth, **promoting the perception of childbirth as a physiological process to banish fears and non-evidence-based interventions**; (f) to **offer legal support**; (g) to promote **independent midwifery studies**; and (g) to **support breastfeeding**.

Since its creation, Childbirth is Ours has served to offer support to women who experience traumatic deliveries; to provide information to pregnant women and their partners; to bring the topic of obstetric violence to the attention of the media; and (d) to reach out to institutions. The association's intervention in the 'discussion' helped move the polemic arena of the debate into the next phase, that of a 'dispute'.

Phase 2 of the debate: 'dispute'

During the second phase of 'dispute', birth rights activism becomes an active party in the debate. In this period, the association Childbirth is Ours plays a role in framing questions and answers as precisely as possible *disputable* issues. Nonetheless, it was often the case that the organisation and its members were placed as 'newcomers' or outcasts in the exchange around birth matters; that is, birthing women were still be seen as tangential or lateral parties in obstetric debates.

Between 2004 and 2007, members of the association **gave talks in civil and professional forums**, such as obstetric conferences, midwifery meetings and breastfeeding courses. They **pointed at obstetric violence and the need to hear mother's voices**. They **contacted the media, ombudsmen, decision-makers and other stakeholders**, and also wrote letters commenting news or reports on birth care.[443] Since their **primary goal was to 'make the issue public'** – that is, to start a discussion in society and to offer proposals for improvement – **some members of the association became very active in the media** to highlight what was later to be labelled 'obstetric violence'.

In 2004, the **short film**, ***Por tu propio bien [For your own good]***,[444] fictionally featured a man delivering a baby to draw attention on how mistreatment is more clearly seen if performed on a man than on a woman. The film ended with the line '*Birth is Ours! Give it back to us!*'', a reference to the name of the birth rights association. Two other **documentaries, produced by Spanish public television**, explored the field: *Los dolores del parto [Birth pains*][445] analysed the rise in caesareans, and (2) *De parto [On Labour]*[446] offered an in-depth analysis of obstetric care in Spain. **Both documentaries interviewed several members**

443 Fernández del Castillo (2004).

444 Icíar Bollaín, *Por tu Propio Bien,* 2004, http://www.youtube.com/watch?v=rxpVqK8oNi0 [accessed 30 July 2013].

445 Francesca Campoy, *Los Dolores del Parto,* http://www.youtube.com/watch?v=ddty4WuUaYU [accessed 30 July 2013].

446 Mariona Ortiz and Anna Masllorens, *De Parto*, http://www.youtube.com/watch?v=ls8UT2WbGkg [accessed 30 July 2013].

of the association to build a general depiction of the problem.

El País, the mostly read newspaper in Spain, **also published two articles**. A well-known journalist, Rosa Montero, wrote the piece **'The disaster of giving birth'**[447] in a Sunday edition in 2006. The article provoked a **flood of supportive letters** by women who thanked the author for highlighting the problem. There were also letters from obstetricians who complained about how the approach of the piece and mentioned the risks of childbirth. Shortly after, a **four-page special main article** about care during childbirth, **entitled 'Childbirth is mine'**, was also published in this same newspaper[448] and led to a cascade of conversations and declarations.

The above description of the dispute reflects a situation in which there is no agreement on the general **framework, goals or values** in the debate save for the fact of the disagreement itself. Hence, the parties attempt to find and present claims and arguments that would fit conclusions known in advance, regardless of their reception by the other party. Nonetheless, disputes are informative: the cognitive gain of disputes consists in better and clearer identification of distinctions between the parties.[449]

Phase 3 of the debate: 'controversy'

During a phase of technical 'controversy', debates that arise around a specific topic soon spread to other issues, thus reflecting a **deep disagreement** as to basic premises in factual, methodological or conceptual matters. But at the same time, **this phase of the debate allows for mutual exchange of perspectives as well as appropriation of the other parties' views.** The continuous dialogue and incorporation of alternative perspectives **generate professional innovation and social change**. For all those premises, the scientific/social debate around childbirth in Spain from 2007 until today can be defined as a 'controversy', in technical terms.

Many of the obstetric controversies relate now to **when and why particular medical interventions are or not necessary** – e.g. they debate on the standard caesarean rates, the use of analgesia or anaesthesia during childbirth, the episiotomies' ratio, or the convenience of vaginal exams after 37 weeks, the handling of the amniotic sac and the prohibition of partners in surgical rooms. Research shows that **linguistic or conceptual innovation** helps to turn a 'discussion' or a 'dispute' into a 'controversy'.[450] Thus, for example, when childbirth activism employs new terms like '**unnecaesarean**', '**caesared woman**', '**dehumanised birth**', '**gynaesaur**' or '**obstetric violence**', it helps shift the field of debate to epistemological 'controversy'. The use of new terms to convey new conceptualisations unveil the deep disagreements while also opening the door for accommodation and negotiation of standpoints.

Childbirth is Ours' actions of approaching the institutions and raise-awareness campaigns, undertaken from 2001 until 2007, **brought a major result**. In 2007, the Spanish Ministry of Health **launched the *Strategy***

447 Rosa Montero, 'El Desastre de Parir', *El País*, 13 August 2006, http://elpais.com/diario/2006/08/13/eps/1155450419_850215.html.

448 Luz Sánchez-Mellado, 'El Parto es Mío', *El País Semanal*, 25 March 2007, http://elpais.com/diario/2007/03/25/eps/.

449 Dascal (2005).

450 Villarmea et al. (2016).

for Care during Normal Childbirth in the National Health System. The *Strategy* incorporated many of the changes suggested by the Parto es Nuestro group. Moreover, it explicitly recognised that the document had been prepared **in response to a demand from women's groups**, health professionals and regional health authorities, and was thus the result of **the combined work of all of them**.[451]

The *Strategy* addressed **a widespread feeling that birth care could be improved by promoting the participation and prominence of women during labour. It even described such participation and prominence as the fundamental objective of the document**. The input of birth rights activism was also emphasised by clearly stating that **women's groups were increasingly demanding the right to give birth with total respect for their privacy, full participation in decision-making and improved conditions for themselves and their babies**. The document referred to the increasing number of health professionals who see this movement as an opportunity for debate and agreement. It emphasised that **women are demanding greater participation in the decisions surrounding birth care**. For those reasons, professional bodies had recently created protocols and guidelines which include revisions of some widely accepted practices.[452] In sum, the whole *Strategy* was presented to ensure the improvement of quality care and recognition of the importance of birthing women's role.[453]

The influence of the *Strategy* and social activism was shown in the subsequent publication of the *Recommendations on Care during Childbirth* in 2008 by the Spanish Society of Gynaecology and Obstetrics (SEGO), which substituted the *Protocol of Care during Normal Childbirth* published in 2003. The introduction signalled that **a conceptual shift had recently taken place in Spain as to obstetric practice and birth care. The essential change was described as placing the mother at the centre of care.[454]** The *Recommendations* say that the SEGO **is making the effort to humanise birth in response to social demand** and to ensure maternal and foetal safety.[455]

Through the years, Childbirth is Ours offered information and **raised awareness among users and health providers through a number of campaigns**, particularly the campaigns: 'Against Routine Episiotomy' and 'Transparency Regarding Obstetric Data' in 2007; 'Never Separate' in 2008; 'Discovering Maternity' and 'Together in Neonatal Intensive Care Units' in 2012; 'Stop Kristeller: A Question of Gravity' in 2013; 'Born During Working Hours' in 2016; and 'Don't Go in Alone' in 2021. All these campaigns contribute to build the present polemic exchange as a field of inventive investigation, where innovations and discoveries lead so much to main cognitive products as to best medical practice.

451 Ministerio de Sanidad (2007).

452 Ministerio de Sanidad (2007).

453 Ministerio de Sanidad (2007).

454 SEGO (2008).

455 SEGO (2008).

Annex 2 - Testimonies

Testimony 1

'I am a worker at a regional hospital and, to my surprise, when I went to give birth at the hospital where I work and everyone knows me, I felt like an object. They broke my bag ***without informing me****. They 'half' forced me to have an epidural, because of the risk to my daughter. They* ***didn't even let me turn around*** *in bed while I dilated. The gynaecologist tried to do the Kristeller manoeuvre, or whatever its name is and when* ***I refused it three times****,* ***she got angry*** *(and then* ***accused me of being hysterical*** *in front of my professional colleagues). After her anger, she* ***stood with her arms crossed*** *behind the midwife and ordered him to do an episiotomy on me, although the midwife himself had told me, before the gynaecologist arrived, that it wouldn't be necessary if we gave him time to get my baby down.'*

Testimony 2

'Things got serious when the other gynaecologist showed up. She ***directly climbed on top of my belly*** *('Kristeller manoeuvre'), causing me unbearable damage since the area was already quite sore after having worn the monitor bands for more than five hours. The other gynaecologist tells me off because '****before you pushed better!****' while I am trying to say that they are doing to me a lot of damage and the gynaecologist is above me mercilessly crushing me and kneading my belly ... Horrible! But it didn't end there ... The 'respectful gynaecologist' went to attend a caesarean section and the other one stayed with me. At that moment, they* ***kicked my partner out*** *of the delivery room. She stood between my legs,* ***told me that they were going to*** *remove my baby with a type of tiny suction cup (they call it a 'kiwi'),* ***did*** *an episiotomy,* ***put the suction cup on me*** *and right away my daughter was out with a bump in her head.'*

Testimony 3

'Her defencelessness made her an ideal candidate for the ***'educational' practice of forceps****. Four students tried to extract the baby with the instrument while the tutor directed them: '****Not like that, you can 'break her head'*** *[verbatim quote from the testimony of the witness in the Preliminary Proceedings followed in the Court of Instruction No 12 of Barcelona]. And they broke it. Of course, this young mother was not told about the indications, benefits, alternatives and potential risks of instrument use, nor was her consent sought. Her permission was not asked for these instruments to be used by students and residents without sufficient skill and training.'*

Testimony 4

'I was in full dilation and someone said: "well, the birth set is right here". And then the gynaecologist said: "to the operating room, to the operating room". And that's

*when they told me: "what's going on? Do you want to push?" And I said: "yes, yes, I'm popping her out! She's coming!" And that's when they laid me down, I see the blue sheet and I say: "**no, no, no, don't do a caesarean section**, I don't want a caesarean section". As soon as I saw it … "but what are you doing? I'm telling you what I want. Well, listen to me at least. Tell me that it can't be this or that… I don't know. But tell me. I mean, tell me something**, don't ignore me!**".'*

Testimony 5

'*She narrates that she herself discovered after her first delivery, in 2002, that she had undergone the so-called "husband stitch": at the time of stitching, the gynaecologist, with a wink, told me that **she was going to leave me like a virgin**. I did not discover until sometime later that this meant that she had narrowed my vaginal opening*'.

Testimony 6

'However, the doctors arrived with the decision made, stating "***caesarean yes or yes, and that's it***". When the author [of the communication, i.e. the claimant] requested information, the doctor did not provide it, but instead infantilised her by replying "*don't worry, I'll take care of you*" … The author requested that the child be given to her father, to which she was told "***calm down, kid, that's it***".'

Testimony 7

'***Most of us had come to motherhood*** *in our thirties* ***with*** *a certain degree of professional and economic security and* ***the feeling that the feminist goals*** *(or at least the 'true' feminist goals like access to work and education, right to abortion and equality before the law)* ***had been fought and won a long time ago***. *We thought we could sit back and enjoy the fruits of our mothers' and grandmothers' struggle without any further effort or contribution to the feminist cause. We thought that sexist discrimination only affected women of the lower social classes.* ***But that was until we gave birth to our own children. Then we were humiliated, infantilised, used and brutally divested by doctors, nurses, and even our own families, of our pride and fantasy that equality had already been achieved***.'

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