Obstetric violence in the European Union: Situational analysis and policy recommendations

by Patrizia Quattrocchi

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OBSTETRIC VIOLENCE IN THE EUROPEAN UNION: SITUATIONAL ANALYSIS AND POLICY RECOMMENDATIONS

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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

Executive Summary

Obstetric violence

This study has been undertaken to inform the European Commission on the issue of obstetric violence in European Union Member States and to contribute to the better understanding of this phenomenon and of current responses to the issue. It is undertaken in the 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 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 sexist behaviour in the course of medical consultations.[1]

There is some criticism of the term 'violence' with the use of 'abuse' and 'disrespect' viewed as better alternatives, and with the World Health Organization (WHO) setting out 'mistreatment' as an overarching term.[2] However, it is argued that the term 'violence' better captures the power structures and gender inequalities that frame any such abuse, disrespect and mistreatment.[3]

Different approaches have been taken in seeking to classify obstetric violence given its multiple dimensions. One key framework applies categories of disrespect and abuse. Bowser and Hill identified seven categories of disrespectful and abusive care during childbirth:[4] physical abuse; non-consensual care; non-confidential care; non-dignified care; discrimination; abandonment of care; and detention in facilities. Bohren et al. proposed the term 'mistreatment', falling into six categories:[5] physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards of care; and poor rapport between women and provider.

This approach has been critiqued for not recognising the structural nature of the issue: the underlying social, political and economic forces that maintain inequality;[6] the connection with gender violence and stereotyping;[7] and systemic power differentials.[8] Freedman et al. presented a framework based on individual, structural and policy-level drivers of disrespect and abuse, encompassing the

1 Council of Europe (2019)

2 WHO (2016).

3 Sadler et al. (2016).

4 Bowser and Hill. (2010).

5 Bohren et al. (2015).

6 See: Mesenburg (2018) and O' Brien & Rich (2022).

7 See: Perrote et al. (2020); Shabot (2016); Villarmea (2020); Zampas (2020) and Amorim et al. (2020).

8 See: Castro (2014a) and Castro & Erviti (2015).

perceptions and norms of healthcare providers and women.[9]

Obstetric violence is a process with multiple causes. These have been usefully summarised by the UN Special Rapporteur on Violence against Women and Girls, its Causes and Consequences in a report from 2019.[10] In the report, the UN Special Rapporteur addresses the phenomenon in the terms of 'mistreatment and violence against women experienced during facility-based childbirth and in other reproductive health services', and takes a structural perspective in establishing root causes as encompassing: health system conditions and constraints; discriminatory laws and practices; harmful gender stereotypes; power dynamics; and abuse of the doctrine of medical necessity.[11]

This study adheres to the term 'obstetric violence' in line with its prominence in scientific research and policy documents, and takes an approach that encompasses a structural perspective.

Prevalence, manifestation and consequences of obstetric violence

The systematic collection of data on obstetric violence at the EU level is limited. A number of quantitative indicators on abuse of medicalisation and interventions are monitored across the EU, including the rates of caesarean sections, episiotomies and induction of labour, and the use of drugs during delivery or after birth such as Haloperidol. The Euro-Peristat initiative has played a valuable role in monitoring a number of these indicators across a wide range of Member States.

The rate of caesarean sections in the Member States (2015–2019 Euro-Peristat data) was found to be higher than 10 % in the 23 Member States for which data was available (data was not available for Bulgaria, Greece, Portugal and Romania):[12] WHO states that a caesarean section rate above this is not associated with reductions in maternal and newborn mortality rates.[13] In terms of vaginal instrumental deliveries, 2019 Euro-Peristat data for the same 23 Member States shows a wide range of incidence, from the lowest in Croatia (1.4 %) to the highest in Spain (14.4 %).

2010 Euro-Peristat data on the incidence of episiotomies on women who delivered vaginally, covering 18 Member States, identified a wide range from 4.9 % in Denmark and 19.8 % in Latvia to 72.9 % in Portugal and 68.2 % in Romania, suggesting the routine use of the procedure in the latter countries.[14] Routine use of episiotomies is not recommended by WHO for women undergoing spontaneous vaginal birth.[15] Data for the same year on induced labour, covering the same 18 Member States, identified a range from below 10 % in the Baltic countries and Czechia to above 20 % in France, Germany, Luxembourg, Malta and the Netherlands. WHO states that the 'routine induction of labour, for women with uncomplicated pregnancies, at less than 41 weeks is not recommended (low certainty evidence)'.[16]

9 Freedman et al. (2014).
10 Šimonović (2019a)
11 Šimonović (2019a).
12 Euro-Peristat (2022).
13 WHO (2015).
14 Euro-Peristat (2010).
15 WHO (2018d).
16 WHO (2022).

A high incidence of caesarean sections, induced labour and episiotomies can signal forms of hyper-medicalisation or the abuse of medicalisation that encompass obstetric violence.

In recent years, research on the prevalence and manifestation of obstetric violence within individual Member States has increased, finding a certain prevalence of different forms of mistreatment of women during childbirth.[17] The studies found that between 21 % and 81 % of the women having given birth that were surveyed had experienced one or more forms of obstetric violence. The findings show that lack of informed consent, non-consented-to care, verbal and physical abuse and lack of communication are issues in the Member States. Over-medicalisation and clinical practices performed that are not based on evidence-based medicine were found to be widespread in the Member States.

It is noteworthy that measuring the prevalence of obstetric violence by specific indicators related to specific manifestations of violence yielded higher figures than when women were asked about their experience of obstetric violence more generally. There is limited multi-country research on the perspectives of women and further research would be needed to establish the reason for this.

Research on obstetric violence has typically been conducted by academics, NGOs and observatories of obstetric violence. The lack of consensus on how abuse and disrespect of women during childbirth in health facilities are to be measured leads to different methodologies for data collection and makes comparisons across the EU difficult.

Obstetric violence can affect certain groups of women with greater severity. Recent studies establish that women with specific characteristics have a greater risk of being exposed to or of suffering violence during childbirth. These characteristics include race/ethnicity, age, socioeconomic status, medical conditions and religion.[18]

In relation to the impact of obstetric violence on women, the consequences on mental health are the most reported.[19] The physical and psychological suffering involved can affect the mother–child relationship and care in the first months of life.[20] The experience can contribute to a loss of trust in the medical field, a decrease in care-seeking in future pregnancies and a decrease in the number of children a woman has in the future.[21] Studies have also shown that healthcare professionals can suffer from being part of a system characterised by obstetric violence and that does not allow women to exercise their human rights in childbirth.[22]

17 See: Bohren et al. (2015); Savage & Castro (2017) and Bohren (2019).

18 See: Brigidi & Busquet-Gallego (2019) and El Kotni & Quagliariello (2021).

19 See: Olza-Fernández (2014); Martinez-Vázquez et al. (2022) and Scandurra et al. (2021).

20 See: Bossano et al. (2017) and Jarillo López et al. (2021).

21 See: Freedman & Krug (2014); Kujawski et al. (2015); Miller & Lalonde (2015); Bohren et al. (2015) and Savage & Castro (2017).

22 See: Olza-Fernández 2014; Barbosa 2017; Oliveira 2017; Martín-Badia et al. 2021; and Fontein-Kuipers et al. 2018.

Policies and initiatives

A range of developments are found in the Member States that address obstetric violence, including legislative approaches, institutional frameworks and a spectrum of initiatives.

A ***legal framework*** can drive change on this issue by allowing some form of redress for obstetric violence, and establishing societal and institutional norms that make such practices unacceptable. Only Portugal has a specific national law on childbirth that explicitly promotes respectful maternity care, human rights or a physiological approach to childbirth. Law n. 110/2019 has an explicit focus on human rights in childbirth. No Member State has passed a national law directly addressing and defining obstetric violence. There are a number of national legislative developments in train, as reported in Italy, Germany Spain, France and Portugal. The only enacted legal measure defining obstetric violence reported was in Spain at the regional level.

Most Member States have a general framework related to Patients' Rights Acts or Healthcare Acts, and health professionals' codes of conduct or ethics, providing norms and recommendations which are applicable to women giving birth and newborns. These serve to advance the minimum standard of care in delivery and birth. Most Member States require informed consent for medical procedures. However, as evident from the data presented on this issue in Section 3.1.3, this is not always put into practice. The data presented on the prevalence of obstetric violence in this study, in particular in Sections 3.1.2 and 3.1.3, suggest that the mere existence of such laws and regulations in which consent is required is clearly not sufficient.

Ministries of health, healthcare organisations, and scientific or health professional associations, by their very mandate are key ***institutions*** which could address obstetric violence in all Member States. Obstetric violence observatories – multidisciplinary bodies that collect, analyse and disseminate data on the issue, and engage in public debate on the issue – are reported in five Member States. Civil society organisations play roles as promoters of initiatives to raise awareness on the topic of obstetric violence, with 47 civil society organisations found that explicitly cover obstetric violence as part of their mandate, in 23 Member States.

A spectrum of initiatives is found across the Member States that reflect key elements that would be required of a strategy to address obstetric violence. These encompass:

- Institutional initiatives to collect and disseminate information, provide mechanisms to address the issues, fund projects and introduce a quality label for maternity care and a redress scheme.
- The publication of guidelines, protocols, statements, position papers and communications covering or mentioning obstetric violence by national umbrella organisations of gynaecologists, obstetricians or midwives, Ministries of Health and other healthcare institutions.
- Legal complaints, court cases, ombudsperson decisions or denunciations relating to obstetric violence (which have been successful in most instances).
- Specific training for doctors, nurses and midwives explicitly addressing obstetric violence.
- Actions to raise public awareness and increase women's engagement in seeking to address obstetric violence.

Case studies undertaken for the purpose of this report – in France, the Netherlands, Slovakia and Spain – emphasise and illustrate the importance of this range of endeavours. The report also highlights research and analysis, which gives visibility to the issue, enables understanding of the issue and its manifestations, and creates a body of evidence to inform the need for and nature of change required. It also highlights examples of advocacy, fighting for sexual and reproductive health rights and raising the public profile of the issue of obstetric violence.

Conclusions and recommendations

The absence of an agreed definition for obstetric violence is a problem. With a definition, legal norms could be established and standards of policy and practice could be framed. Moreover, the lack of an agreed framework through which to analyse, understand and make provisions in relation to the issue of obstetric violence impedes an effective and uniform response. Any such framework would usefully address obstetric violence as an issue of gender-based violence, a form of institutional violence, and a violation of human rights.

The systematic collection of data on obstetric violence at the EU level is limited. There is a lack of national data and standardised tools to measure the prevalence of obstetric violence across the Member States. Despite shortcomings, the available data does convincingly demonstrate that obstetric violence is a prevalent and harmful issue across the Member States.

Many factors contribute to securing action on and reducing levels of obstetric violence: legal frameworks, research and analysis, mandated institutions and a range of initiatives encompassing research and analysis, institutional initiatives, guidance documents, legal casework, training for health professionals, awareness raising and advocacy. However, it is clear that a more comprehensive spread of such developments is required across the Member States and a more strategic deployment and interaction of these elements is required for impact.

At the European Union level, it is recommended that the European Commission:

- Facilitates exchanges among Member States on the issue of obstetric violence, including through Mutual Learning Seminars with Member States, in particular by:
  - sharing information on developments and good practice in addressing obstetric violence at the Member State level and developing models for good practice for the various elements required to address obstetric violence;
  - promoting dialogue and peer support on responding to the issue of obstetric violence between the stakeholders and across the Member States, strengthening commitment and expertise.
- Mandates the European Institute for Gender Equality ('EIGE') to develop a set of quantitative and qualitative indicators to measure the prevalence and manifestation of obstetric violence.
- Through relevant EU financing programmes, fund projects on obstetric violence, including with the purpose to:
  - reviewing the legal and policy frameworks in Member States and at the different governance levels to combat obstetric violence, including in par-

ticular, the minimum standards of care in maternity and perinatal care, in order to identify a standard for such a legal framework, and to flag possible gaps in the legal frameworks of Member States;

- conducting policy research in the field to further explore the causes of obstetric violence, its manifestations and consequences, and the quality and impacts of the policy initiatives adopted to respond to this issue;
- exploring available avenues for patients to report cases of obstetric violence and seek redress.

At the Member State level, it is recommended that the Member States and their relevant institutions:

- Review their legal framework in place and ensure it is adequate to address obstetric violence, establish norms on the issue, and provide for redress.
- Develop and ensure implementation of protocols and guidelines for healthcare institutions and professionals to prevent and eliminate obstetric violence.
- Promote, support and implement programmes of awareness-raising and training for relevant healthcare professionals, including midwives, gynaecologists, neonatologists, nurses and paediatricians, health system personnel, staff of private and public health organisations providing care, and students. This awareness and training would update their knowledge, promote maternity and childbirth standards, and inform their capacity to meet these standards consistently.
- Promote and resource evidence-based academic studies and policy research in the field to further explore, within a structural framework, the causes of obstetric violence, its manifestations and impact, and the impacts of the policy initiatives adopted to respond to this issue.
- Advance the development and implementation of national monitoring systems, with a view to tracking incidence and forms of obstetric violence, and to monitoring changes over time.
- Promote, support and resource civil society initiatives to raise awareness of the issue of obstetric violence, to advocate for change on this issue, to inform women of their rights in this regard, and to provide support to women who seek to exercise these rights.

1. Introduction

1.1. Obstetric violence

Obstetrics is the medical discipline that deals with pregnancy, childbirth and the post-partum period. It is a narrower field than that of gynaecology.[23] Obstetric violence has emerged as a focus for concern in European and international policy, research and debate. Legal definitions are not found at the national level in the Member States.[24]

In 2007, Venezuela was the first country in the world to define obstetric violence as a legal issue, within a law against gender-based violence. Article No. 15 of the 'Organic law on women's rights to a life free of violence' defines obstetric violence as:

> *'the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanised treatment, an abuse of medication and conversion of the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.'* [25]

There is growing evidence that women experience abuse and disrespect during childbirth in health service facilities worldwide.[26] The so-called 'too much, too soon' process, which often characterises the maternal care provided in high-income countries, contrasts with the 'too little, too late' process that characterises the care provided in middle- or low-income countries.[27] In both cases, inappropriate medical care is given (hyper-medicalisation in the former, and under-medicalisation in the latter) and obstetric violence can be experienced.

The Council of Europe defines this issue in terms of:

> *'In the privacy of a medical consultation or childbirth, women are victims of practices that are violent or that can be perceived as such. These include inappropriate or non-consensual acts, such as episiotomies and vaginal palpation carried out without consent, fundal pressure or painful interventions without anaesthetic. Sexist behaviour in the course of medical consultations has also been reported.'*[28]

Unnecessary interventions are considered an abuse and a pathologisation of a natural process in some conceptualisations of obstetric violence.[29] High rates of caesarean sections, episiotomies or Kristeller manoeuvres, vaginal examinations

23 Gynaecology is a medical discipline that deals with female health care concerns including the development, diagnosis, prevention and therapy of disorders and diseases distinct to the female reproductive system.

24 Law No. 17 enacted in Catalonia modifies Law 5/2008 on 'The rights of women to eradicate sexist violence' does include a definition of obstetric violence, for this regional level in Spain (see Section 4.2.3).

25 República Bolivariana de Venezuela (2007: 7).

26 See: WHO (2015); Savage & Castro (2017); Bohren et al. (2015); Bohren et al. (2019); Perrotte et al. (2020) and Faheem (2021).

27 Miller et al. (2016).

28 Council of Europe (2019).

29 Sadler et al. (2016).

and induced labour, are considered as indicators of inappropriate care by WHO.[30]

Obstetric violence during childbirth is not only about the pregnant woman, it can also affect the baby. Although this is an area not yet sufficiently analysed, issues have been noted of: lack of respect for the physiological timing of labour and delivery (speeding up or inducing drugs are practices that affect not only the mother but also the unborn child); different means of giving birth not being considered equally (vaginal births, birth by caesarean section or with forceps); standardised and/or unnecessary practices conducted in the first hours of life (non-delayed clamping, non-urgent clinical and diagnostic tests); lack of respect for the timing of bonding and adaptation of the baby to the new environment; making it impossible to be breastfed immediately after birth; and enforced separation from the mother in neonatal Intensive Care Units.[31]

The term 'violence' has been criticised by some as being provocative, especially by and for health professionals.[32] The terms 'abuse' and 'disrespect' have been proposed and used as alternatives at the European level and elsewhere. WHO has set out the use of 'mistreatment' as an overarching term.[33] On the other hand, it has been argued that the term 'violence' is needed, to highlight the power structures and gender inequalities that frame the abuse, disrespect and mistreatment involved.[34] This report adheres to the term 'obstetric violence' in line with its prominence in scientific research and policy documents.

1.2. This study

The general objective of this study is to inform the European Commission on the issue of obstetric violence in European Union Member States and contribute to the better understanding of this phenomenon. The specific objectives of this study are to:

1. Develop a conceptual framework for this phenomenon, with a focus on the genesis of the concept of obstetric violence, and definitions and types of obstetric violence that best apply to the EU context.
2. Present and discuss information on:
    a. the prevalence of victims of obstetric violence among women who experienced childbirth in its various forms; and
    b. the perspective and narratives of victims of obstetric violence.
3. Provide an overview of existing policies and initiatives in relation to obstetric violence in the Member States, including public policies specific to healthcare providers.
4. Explore the role of different stakeholders in the Member States, identifying likely support and resistance to policy development in this area.
5. Distinguish different types of policies and initiatives and their ability to address specific aspects of the problem at European Union and Member States levels.

30 WHO (2018a) and WHO (2018b).

31 See: López et al. (2021); Stantoi & Gogoi (2022) and Tolton (2022).

32 See: Diniz et al. (2015); Sesia (2020); Bohren (2018b) and Macia (2019).

33 WHO (2016).

34 Sadler, M., et al. (2016).

1.3. Study background

1.3.1. Growing public awareness of and concern about obstetric violence

Abuse and disrespectful care during childbirth, key components of obstetric violence, have been highlighted by international and interdisciplinary research as an urgent global health topic and human rights issue.[35] There is increasing and reliable research on obstetric violence following different approaches[36] and metrics.[37] There is increasing availability of survey data, informing reports on the prevalence of obstetric violence in several countries, particularly in Latin America and Africa,[38] and of qualitative data.[39] Such data and reports are found in the EU Member States and are identified in this study.

Obstetric Violence Observatories or other types of monitoring instruments have been implemented by international and national non-governmental organisations and other civil society organisations in many countries.[40] Media campaigns and public debate on the topic have also increased in many countries, sometimes leaving traces in grey literature.[41]

This body of work and initiative has led to increased public awareness of and concern about the issue of obstetric violence.

1.3.2. Imperative of quality care at childbirth and focus on perinatal outcomes

WHO has emphasised that a 'positive birth experience' is a crucial aspect of high-quality birth care and not 'just complementary to provision of routine clinical practices'.[42] The 'good outcome' of a birth should be assessed by also taking the quality of women's and newborns' experiences into account, including in terms of respectful care, effective communication, preservation of dignity, emotional support, and basic steps to prevent mistreatment and harmful practices.[43]

Access to high-quality healthcare at childbirth is key for good perinatal outcomes and for the future physical and mental health of new parents and their babies. Member States show good results in this area according to 2019 data from the Euro-Peristat project. [44] Positive achievements have been made possible by medicalising childbirth, with maternal mortality a rare event and infant mortality and pre-term births at low and decreasing levels.[45] However, in some circumstances, medicalisation has gone too far without bringing notable improvements in childbirth outcomes. The number of caesarean sections is considered as an indicator of over- or hyper-medicalisation, and there is a wide disparity found in the incidence of caesarean sections and instrumental mode of delivery across

35 See: WHO (2014a) and Khosla et al. (2016).

36 See: Savage & Castro (2017) and Ferrão et al. (2022).

37 See: Vogel et al. (2015); Boheren et al. (2018) and Castro & Frías (2020).

38 See: Boheren et al. (2019); Tobasía-Hege et al. (2019) and Castro & Frías (2020).

39 See: Savage & Castro (2017).

40 See: Villarmea et al. (2015); Brigidi & Busquet Gallego (2019); Quattrocchi (2019a); Gonzáles (2020) and Saulo (2022).

41 See: WHO (2016) and Lazzerini (2019).

42 WHO (2018c).

43 See: WHO (2016) and Lazzerini (2019).

44 The Euro-Peristat project financed by the European Commission produces comparable data and analysis of the health and care of newborn babies and mothers using national data systems. See: https://www.europeristat.com/

45 Euro-Peristat (2022).

the Member States, reaching high levels in a number of Member States.[46]

WHO has pointed out that 'practices to initiate, accelerate, terminate, regulate or monitor the physiological process of labour, may undermine the woman's own capability to give birth and negatively impact her childbirth experience' and recommended indications for doctors and midwives for the specific cases when intervention is needed.[47] These practices involve risks for the health of the mothers and of the babies. WHO noted that such medicalisation may become a driver of obstetric violence as its pursuit, even with the informed consent of the patient, can be negatively experienced by women in the particular conditions of childbirth.[48] WHO has long recommended a rethink of the approach to possible health risks in vaginal spontaneous delivery and for childbirth to be addressed as a natural process and not as a medical event.[49]

1.3.3. Acknowledgement of obstetric violence as a violation of human rights and as a form of gender-based violence and institutional violence

The WHO statement, 'The prevention and elimination of disrespect and abuse during facility-based childbirth', declares that abuse and disrespect in childbirth not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity and freedom from discrimination.[50] Mistreatment during childbirth, thus, represents a violation of women's fundamental human rights.

The UN Special Rapporteur on Violence against Women, its Causes and Consequences submitted a report in 2019 to the United Nations General Assembly: *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence.*[51] This report defined obstetric violence as a form of gender-based violence that occurs 'in the context of structural inequality, discrimination and patriarchy' as a 'consequence of a lack of education and training, as well as a lack of respect for women's equal status and human rights'.

The European Parliament (EP) adopted the resolution of 24 June 2021 'On the situation of Sexual and Reproductive Health and Rights (SRHR) in the EU, in the frame of women's health'.[52] This resolution takes a human rights–based approach to women's health, qualifies the phenomenon of obstetric violence as a specific form of gender-based violence, and establishes SRHR as being grounded in fundamental human rights. The resolution encourages Member States to take a step forward compared to the current state of play on the Health of the European Union which is regulated by Directive 2011/24/EU[53] on the application of patients' rights in cross-border healthcare and the Council Recommendation 2009/C

46 Euro-Peristat (2022).

47 WHO (2018:1).

48 WHO (1996).

49 WHO (1996).

50 WHO (2015).

51 Šimonović (2019).

52 European Parliament resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health (2020/2215(INI)).

53 Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32011L0024

151/01 on Patient Safety.[54] – a step the European Parliament considers feasible despite the boundaries posed by Article 168 of the Treaty of the Functioning of the European Union, paragraph 7, which is often seen as an obstacle to a more homogeneous health policy across the EU.[55]

Obstetric violence can be understood as a specific form of violence that involves gender-based violence and institutional violence, and that constitutes a violation of human rights, including the right to health and the right to reproductive autonomy.[56]

1.4. Study approach

The preparation of this study involved a review of EU and international research and data sources; analysis of desk research undertaken by the SAAGE EU-27 country experts in summer 2022, covering national data sources and national literature[57]; and in-depth analysis in four Member States through case studies[58], based on common guidelines and undertaken in the third quarter of 2022 by national experts in Spain, France, the Netherlands and Slovakia, selected for a diversity of geographical locations, social and cultural contexts, obstetric practices and healthcare systems, and data availability.

The study is structured into five sections:

- Chapter 1 sets out the study background, objectives and approach.
- Chapter 2 presents a conceptual framework for analysing obstetric violence.
- Chapter 3 presents quantitative data and qualitative issues emerging from the literature review in the Member States, with a focus on prevalence and manifestation of obstetric violence experienced by women in the Member States, and the main characteristics of women at risk.
- Chapter 4 provides an overview of policies and initiatives to tackle obstetric violence in the Member States.
- Chapter 5 provides elements of importance for progressing change in relation to obstetric violence, based on the case studies.
- Chapter 6 presents conclusions and recommendations.

A glossary is provided at the end of the study and the four case studies are presented in a separate volume annexed to the report.

54 Council Recommendation of 9 June 2009 on patient safety, including the prevention and control of healthcare associated infections. Available at: https://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX-%3A32009H0703%2801%29

55 Bartlett, and Naumann (2020).

56 See: WHO (2015) and Šimonović (2019).

57 The country experts are: Anna Amilon, Rose Marie Azzopardi, Ursula Barry, Ruta Braziene, Ivanka Buzov, Nadja Bergmann, Lina Coelho, Malgorzata Druciarek, Anne Eydoux, Virginia Ferreira, Thomas Georgiadis Elvira Gonzalez Gago, Aleksandra Kanjuo-Mrcela, Alena Krizkova, Danièle Meulders, Anita Nyberg, Rositsa Pavlova, Anna Pilavaki, , Robert Plasman, Raluca Popescu, Alexandra Scheele, Mari-Liis Sepper, Claudia Sorger, Hanna Sutela, Dorottya Szikra, Platon Tinios, Giovanna Vingelli and Anna Zasova.

58 The complete case studies are presented in a separate volume. The authors of the case studies listed by country (in alphabetical order) are: Virginie Rozée and Clémence Schantz for France, Rodante van der Waal and Marit van der Pijl for the Netherlands, Barbora Holubova for the Slovak Republic, and Stella Villarmea and Adela Recio Alcaide for Spain.

2. Obstetric Violence: Dimensions and Causes

2.1. Introduction

Obstetric violence is a process with multiple dimensions and causes that intertwines gender-based violence, institutional violence and violations of human rights to health and reproductive health during childbirth. The multiple dimensions and causes of obstetric violence means this type of violence is multifaceted. Obstetric violence cannot be considered just a product of a single provider's intentional behaviour during childbirth. It is a broader structural and cultural issue, in which social forces, agencies and powers are involved.

2.2. Obstetric violence as a phenomenon with multiple dimensions

Obstetric violence can take various forms. Different approaches have been taken to classify this phenomenon given its multiple dimensions. One key framework applies categories of disrespect and abuse but has been critiqued for not addressing the structural nature of the issue. Other approaches have been taken to classify this phenomenon in more structural terms.

Bowser and Hill, as part of the United States Agency for International Development (USAID) Translating Research into Action project in 2010, published an analysis that synthesised existing research, to develop a classification of obstetric violence according to seven categories of disrespectful and abusive care during childbirth.[59] A list of rights corresponding to these categories was developed by the White Ribbon Alliance in 2011.[60]

59 Bowser and Hill (2010).

60 White Ribbon Alliance (2011).

Table 1: Categories of disrespect and abuse

Categories of disrespect and abuse	Examples	Corresponding rights[61]
Physical abuse	Unnecessary procedures Slapping during delivery Physically restraint during delivery	Freedom from harm and ill treatment
Non-consensual care	Imposing temporary or permanent contraception after delivery, or forced caesarean sections for non-vital medical reasons Patient's permission not asked before performing a procedure	Right to information, informed consent, and refusal, and respect for the person's choices and preferences, including companionship during maternity care
Non-confidential care	Absence of curtains or a blanket during examinations	Privacy and confidentiality
Non-dignified care	Forcing patients to deliver in lithotomy position even if not necessary Joking about patient's pain	Dignity and respect
Discrimination	Talking in a language that patients do not understand Allowing medical students to perform unnecessary medical procedures on patients in public facilities to learn, while refraining to do so for patients with private healthcare	Equality, freedom from discrimination and equitable care
Abandonment of care	Delivering without skilled birth attendants Discharging patients against their will if refusing recommended treatment	Right to timely healthcare and to the highest attainable level of health
Detention in facilities	Detaining in facility for failure to pay	Liberty, autonomy, self-determination and freedom from coercion

Source: Bowser & Hill (2010).

Bohren et al. reorganised the seven categories of abuse and respect of Bowser and Hill into six categories, and proposed the term 'mistreatment' as a broader term.[62] They developed evidence-informed, validated tools to measure mistreatment in different countries, using mixed methods (direct observation and women's self-reports).

61 White Ribbon Alliance (2011).

62 Bohren et al. (2015).

Table 2: Categories of mistreatment

Type of mistreatment	Examples
Physical abuse	Women beaten, slapped, kicked or pinched during birth. Women physically restrained to the bed or gagged during birth.
Sexual abuse	Sexual abuse or rape.
Verbal abuse	Harsh or rude language. Judgemental or accusatory comments. Threats of withholding treatment or poor outcomes.
Stigma and discrimination	Discrimination based on ethnicity, race, religion, socioeconomic or medical conditions, age.
Failure to meet professional standards of care	Lack of informed consent process. Breaches of confidentiality. Painful vaginal examinations. Refusal to provide pain relief. Performance of unconsented surgical operations. Neglect, abandonment or long delays. Skilled attendant absence at time of birth.
Poor rapport between women and providers	Ineffective or poor communication. Lack of supportive care. Loss of autonomy. Dismissal of women's concerns. Language and interpretation issues. Poor staff attitudes. Denial or lack of birth companions. Women treated as passive participants during childbirth. Denial of food, fluids or mobility. Lack of respect of women's preferred birth positions. Denial of safe traditional practices.

Source: Bohren et al. (2015).

Limitations in this approach to classification have been highlighted. While not all forms of potential disrespect and abuse are mentioned, Freedman et al. state that these categories 'describe types of disrespect and abuse that happen in health facilities, but do not define it in terms of the characteristics of health-care provider behaviour, facility conditions or other factors that could be construed as disrespectful and abusive'.[63] Sadler et al. identified that the concepts of abuse and disrespect have highlighted the problem at the micro level of healthcare practitioners who fail to meet a minimum standard of care, but they do not pay attention to power structures and gender inequalities that frame such lack of care and exercise of violence.[64] Instead, the term 'obstetric violence', by focusing on these dimensions, 'has the potential for addressing the structural dimensions of violence within the multiple forms of disrespect and abuse'.[65]

This structural approach references the social, political and economic forces that produce and maintain inequalities that legitimate violence against individuals;[66] gives expression to the connection with gender-based violence and stereotypes that comes from a patriarchal perspective;[67] underlines the power dynamics between health professionals and patients,[68] maintained by a system that women

63 Freedman et al. (2014).

64 Sadler et al. (2016).

65 Sadler et al. (2016: 3).

66 See: Mesenburg (2018) and O' Brien & Rich (2022).

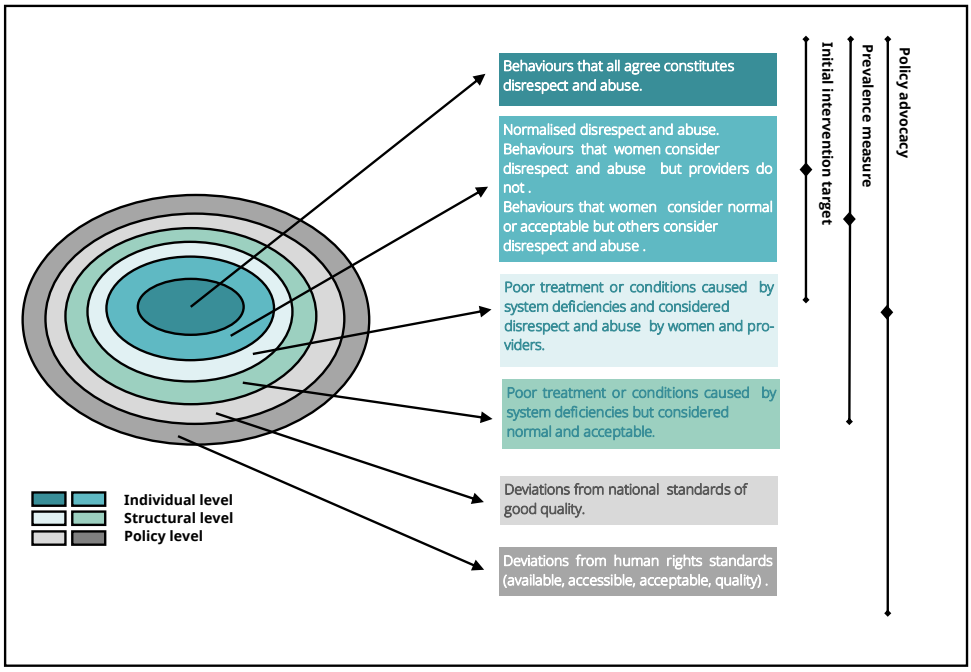
67 See: Perrote et al. (2020); Shabot (2016); Villarmea (2020); Zampas (2020) and Amorim et al. (2020).

68 See: Castro (2014) and Castro & Erviti (2015).

adapt to[69] and biopolitical dimensions,[70]; and allows for addressing multiple intersecting forms of discrimination.[71] Obstetric violence, for instance, is reported to be more prevalent among people of colour globally,[72] among women with less education and living in rural settings, and among unmarried and indigenous women.[73]

Freedman et al. suggest a new framework based on individual, structural and policy-level drivers of disrespect and abuse, taking into account the perceptions and norms of healthcare providers and women. [74]

Figure 1: Defining disrespect and abuse of women in childbirth



Source: Freedman et al. (2014).

Systematic reviews on obstetric violence have been published in recent years, taking this more structural approach.[75]

69 See: Castro & Savage (2019).

70 See: Bellón Sánchez (2015).

71 See: Davis (2019); Castro et al. (2015); Perrotte et al. (2020); Sesia (2020); Espinoza-Reyes & Solís (2020); Brigidi & Busquets-Gallego (2019); El Kotni & Quagliariello (2021); Soveraign (2021) and Giacomozzi et al. (2021).

72 See: Davis (2019) and Fracker (2022).

73 See: Dixon (2015); Castro & Frías (2020); Dawson & Suntjens (2022); Kisitu (2022); ENVIGMU (2019), Chattopadhyay et al. (2018) and Vedam et al. (2019).

74 Freedman et al. (2014).

75 See: Jardim & Modena (2018); Garcia (2020); Faheem (2021); Ferrão et al. (2022) and specific thematic volumes have been published: Quattrocchi & Magnone (2020); Castaneda et al. (2022) and Castro & Frías (2022).

2.3. Obstetric violence as a phenomenon with multiple causes

Obstetric violence is a process with multiple causes. While obstetric violence is committed by health personnel (most of whom are women), it is facilitated and perpetuated by health systems as a whole. Most of the time, it is not due to individual intentional violence, but is produced by the interweaving of multidimensional structural factors.

Health inequity emerges as a foundation for the phenomenon of obstetric violence. Weinstein et al. identify two main clusters of root causes of health inequity, which also apply to the birth process:

- 'The intrapersonal, interpersonal, institutional, and systemic mechanisms that organise the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expression, and other dimensions of individual and group identity …
- The unequal allocation of power and resources, including goods, services, and societal attention, which manifest in unequal social, economic, and environmental conditions, also called the social determinants of health'.[76]

Obstetric violence is inflicted by healthcare providers (intentionally or not) but also by health systems as a whole, when:

- The conditions in hospitals and clinics deviate greatly from accepted standards of care.[77]
- Pathological, interventionist and hierarchical approaches to birth and pregnant women are so normalised that they do not allow women, health professionals and stakeholders to recognise or mitigate the abuse.[78]

Technology is important and beneficial, when needed, for monitoring and managing the delivery and birth, but birth is a multidimensional biological, psychological, social and cultural process, in which the competences of women and their babies need to be taken into account, and women's competences are devalued or not taken into account in this technocratic model of birth.[79]

The UN Special Rapporteur on Violence against Women and Girls, its Causes and Consequences identified and usefully summarised the root causes of mistreatment and gender-based violence in delivery and childbirth as encompassing:

- ***Health system conditions and constraints***. This refers, for instance, to the lack of resources, poor or stressful working conditions, lack of autonomy of midwives and professional hierarchies, and lack of appropriate or insufficient training of health professionals.
- ***Discriminatory laws or practices***. This refers, for instance, to laws or practices restricting women's choice and autonomy on reproductive health processes; or to discriminatory practices, such as forced sterilisation, against specific type of women, based on age, ethnicity, socioeconomic conditions, medical conditions, etc.
- ***Gender stereotypes***. This refers to women's and men's roles in societies, i.e. women's 'natural' role as a mother and caregiver, perceptions that childbirth

76 See: Weinstein et al. (2017: 119).

77 Freedman, Kruk (2014).

78 Castro and Erviti (2015).

79 Davis-Floyd and Sargent (eds.) (1997).

is an event that requires a woman to suffer, and false assumptions of women's decision-making competence. All of these serve to undermine women's autonomy and agency.

- ***Power dynamics and the abuse of the doctrine of medical necessity***. This reflects, for instance, the power of authoritative medical knowledge and the social privilege of medical authority held by the health provider, such that the relationship between doctor and patient is based on a power imbalance.[80]

80 Šimonović (2019)

3. Obstetric Violence in the EU

3.1. Prevalence and manifestation of obstetric violence in the EU

3.1.1. Availability of data on prevalence and manifestation of obstetric violence in the EU

The systematic collection of data on obstetric violence at the EU level is limited. There are some studies which cover several European countries. In recent years, research on the prevalence and manifestation of obstetric violence within individual Member States has increased. Such studies within Member States are typically conducted by academics and by NGOs or observatories of obstetric violence.

However, there is a lack of consensus among scholars on how abuse and disrespect of women during childbirth in health facilities is to be measured. The collection and analysis of data differs across studies, due to different methodologies of data collection, i.e. categories, tools and timing. This makes comparison among countries, studies and regions difficult.[81] Nevertheless, in recent years, a growing number of studies have shown a certain prevalence of different forms of mistreatment of women during childbirth.[82]

Quantitative and qualitative research is reported and both add value to an understanding of obstetric violence. Quantitative research, with its basis in the collection and analysis of numerical data, provides the potential to establish scales and patterns of obstetric violence and its various forms. Where samples are representative, it further allows generalisation to the total population. Qualitative research, with its basis in personal accounts, interviews and observation, provides the potential to better understand the experiences and perspectives of those involved in obstetric violence.

The desk research carried out at the national level for this study found that regional and local research providing **quantitative data** is available in 15 Member States. No national surveys were identified that were carried out by governmental bodies and address specific indicators of obstetric violence. Definitions, instruments and methods used to measure practices that are harmful and disrespectful of women in childbirth were found to vary across the different studies. As stated previously, comparison across countries and regions is therefore difficult.

The desk research carried out at the national level for this study found **qualitative information** was available in 16 Member States. The qualitative information identified was collected by academics, activists and civil society organ-

81 Sando et al. (2017).

82 See: Bohren et al. (2015); Savage & Castro (2017) and Bohren (2019).

isations and found mainly by way of interview. Bowser and Hill's categories of disrespect and abuse and Bohren et al.'s typology of mistreatments (see Section 2.2) are used by a number of scholars, even if specific categories and topics are sometimes added or redefined.

3.1.2. Quantitative indicators of prevalence and manifestation of obstetric violence in the EU

A number of quantitative indicators on abuse of medicalisation and interventions (such as the rates of caesarean sections, episiotomies and induction of labour, and use of drugs during delivery or after birth such as Haloperidol) are monitored across the EU. A high incidence of such indicators, such as caesarean sections, induced labour and episiotomies, can signal obstetric violence in the form of hyper-medicalisation or abuse of medicalisation. The Euro-Peristat initiative has been valuable in monitoring a number of such indicators.[83]

The collection of data on these practices is useful to monitor appropriate care in the birth process, as well as divergent practices in different countries. Available data refers to the incidence of deliveries by caesarean sections, vaginal instrumental deliveries, episiotomies and induced labour. Induced labour can include the use of drugs for cervical ripening and oxytocin, and in some instances, involve the artificial rupture of membranes.

The rate of caesarean sections for 2015 to 2019 in the Member States in all the 23 Member States for which data was available was higher than 10 %.[84] WHO states that caesarean sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons, and that, at the population level, caesarean section rates higher than 10 % are not associated with reductions in maternal and newborn mortality rates.[85] When higher than 10 %, the rate of caesarean sections is associated with higher risks for women's health.[86]

The incidence of caesarean sections in 2019 was lowest in the Netherlands (17.4 %), and also low in the Nordic and Baltic countries (17.9 % in Finland, 18.2 % in Sweden and 20.3 % in Estonia, for example). It was highest in southern and central European countries (53.1 % in Cyprus, 44.4 % in Poland and 41.5 % in Hungary, for example) and in Ireland (34.8 %). The median rate was 26 %.

The profile of women plays an important role in determining this diversity, for example, higher ages in pregnancy, but there are other factors noted as important, such as the sociocultural context and the organisation of health systems.

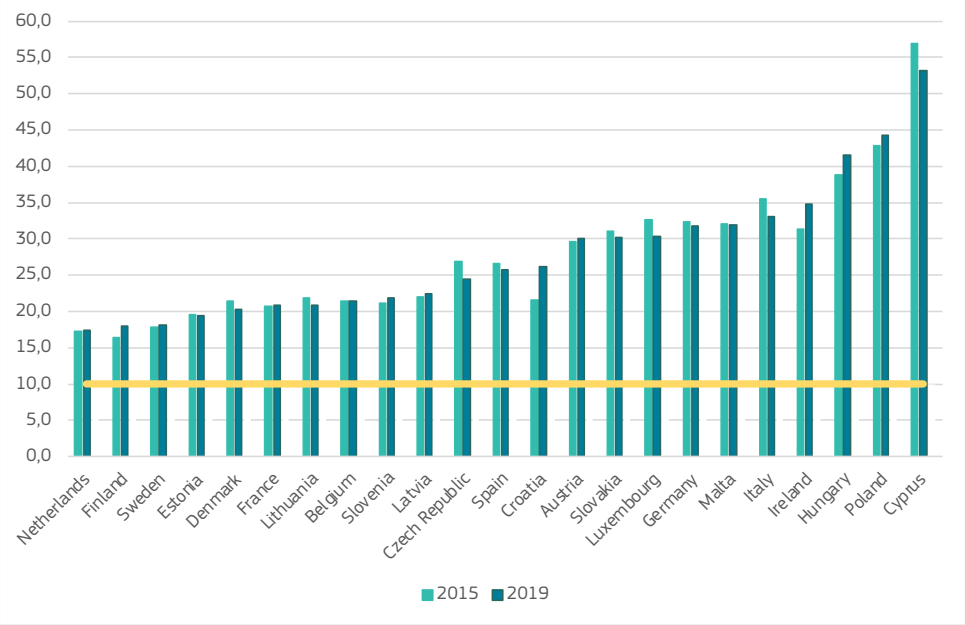
83 The Euro-Peristat Network, began in 1999 as part of the EU's Health Monitoring Programme, now has official representation from 31 countries across Europe and a large network of contributing experts, and works to establish a high-quality, innovative, internationally recognised and sustainable European perinatal information system to produce data and analysis on a regular basis for use by national, European and international stakeholders who make decisions about the health and healthcare of pregnant women and newborns.

84 See: Euro-Peristat (2022). Data was not available for Bulgaria, Greece, Portugal and Romania, while the report also included data for Iceland, Norway, Switzerland and the United Kingdom.

85 WHO (2015).

86 See: Betrán et al. (2015) and Sandall et al. (2018).

Figure 2: Share of women giving birth by caesarean section, 2015 and 2019



Source: Euro-Peristat 2020.

Data on vaginal instrumental deliveries is available for 2019 from the same Euro-Peristat report and, likewise, cover the same 23 Member States. The rate of vaginal instrumental deliveries has a wide range, at its lowest in Croatia (1.4 %) and Lithuania (1.6 %) and at its highest in Spain (14.4 %) and Ireland (13.9 %).

The incidence of episiotomies on women who delivered vaginally is another indicator of obstetric violence. Figures on this practice are available from Euro-Peristat[87] but refer to the year 2010 and cover 18 Member States.[88] The rate was low in the Nordic countries such as Denmark (4.9 %) and Sweden (6.6 %) followed by the Baltic countries such as Latvia (19.8 %) and Estonia (16 %). However, it was high in southern and central European countries such as Cyprus (75 % in 2007), and Portugal (72.9 %), and Romania (68.2 %) and Poland (67.5 %), suggesting the routine use of the procedure. Routine use of episiotomies is not recommended by WHO for women undergoing spontaneous vaginal birth.[89]

Similarly, figures on induced labour are available from Euro-Peristat[90] but refer to the year 2010 and cover the same 18 Member States.[91] The incidence of induced labour ranged between 6.8 % in Lithuania to 20 % in Malta. It was lowest (below 10 %) in the Baltic countries and Czechia, and it was highest (above 20 %) in France, Germany, Luxembourg, Malta and the Netherlands. WHO has stated that the 'routine induction of labour, for women with uncomplicated pregnancies, at less than 41 weeks is not recommended (low certainty evidence)'.[92]

87 Euro-Peristat (2010).

88 Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Latvia, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden.

89 WHO (2018d).

90 Euro-Peristat (2010).

91 See footnote 81.

92 WHO (2022).

Some studies suggest that during the Covid-19 pandemic, obstetric violence increased.[93] In particular, evidence was noted of the increased medicalisation of care, a high rate of interventionism, low support for care and breastfeeding (including not allowing rooming-in) and violations of human rights in childbirth and reproductive health services, such as the unnecessary separation of the baby from the mother.

3.1.3. Qualitative studies on prevalence and manifestations of obstetric violence

Only two multi-country studies were found that provided information from the perspective of the women involved on the prevalence of obstetric violence in Europe. A 2015 study conducted in six Northern European countries (EU/EEA countries: Belgium, Iceland, Denmark, Estonia, Norway and Sweden) among 6 923 pregnant women reported that one in five pregnant women attending routine antenatal care reported one or more forms of abuse in healthcare.[94]

A 2022 survey on the quality of maternal and newborn care, as defined by WHO standards, during the Covid-19 pandemic, was carried out in 12 European (EU and non-EU: Italy, Sweden, Norway, Slovenia, Portugal, Spain, Germany, Serbia, Romania, France, Croatia and Luxembourg) with 21 027 mothers included in the analysis.[95] Multivariate analyses confirmed significant differences among countries, with Croatia, Romania and Serbia showing significant lower quality of maternal and newborn care on the relevant indexes and Luxembourg showing a significantly higher score than the total sample. Findings included:

- 41.8 % of surveyed women experienced difficulties in accessing antenatal care
- 31.1 % received inadequate breastfeeding support
- 42 % of women with spontaneous vaginal birth could not choose their birth position
- Episiotomy was performed in 20.1 % of spontaneous vaginal births (from 6.1 % in Sweden to 66 % in Romania) and fundal pressure applied in 41.2 % of instrumental vaginal births (from 11.5 % in France to 100 % in Romania)
- 23.9 % of women felt they were not treated with dignity
- 12.5 % suffered abuse.

In relation to informed consent, the study found 34.7 % of women did not feel involved in choices related to the medical interventions received (ranging from 21.7 % in Luxembourg to 77.2 % in Serbia) and, among those who underwent labour, 53.6 % did not provide consent for an instrumental vaginal birth (ranging from 35.9 % in Sweden to 81.8 % in Croatia).

Relevant qualitative studies were found from 15 Member States (Belgium, Croatia, France, Germany, Hungary, Ireland, Italy, Lithuania, Latvia, the Netherlands, Poland, Portugal, Slovenia, Slovakia and Spain).[96] The studies identified that be-

93 See: Sadler et al. (2020); Davis-Floyd et al. (2022) ; Sweet et al. (2022); Lazzerini et al. (2019) and Lazzerini (2022).

94 Lukasse, M., et al. (2015).

95 Lazzerini, M., et al. (2022).

96 Belgium: Anissa et al. (2021); Croatia: Roditelji u akciji – Roda (2019), Roditelji u akciji – Roda (2020); France: Arthuis et al. (2022); Germany: Limmer et al. (2021), Reuther (2021); Greece: Antoniou (2021); Hunga-

tween 21 % and 81 % of the women surveyed who gave birth experienced one or more forms of obstetric violence. It is noteworthy that measuring the prevalence of obstetric violence by specific indicators related to specific manifestations of violence yields higher figures than when women are asked about their experience with obstetric violence more generally. There is limited multi-country research found on the perspectives of women and further research would be needed to establish the reason for this. The wide range in prevalence found in these studies reflects that obstetric violence is measured through different measures and with different definitions adopted. Further research is needed, however, to determine the impact of this diversity on the resulting prevalence data.

The findings show that lack of informed consent and non-consented-to care, verbal and physical abuse, and lack of communication are issues in Member States. Over-medicalisation and clinical practices not based on evidence-based medicine are widespread in the Member States. These include the Kristeller manoeuvre, repetitive vaginal examinations, the systematic use of oxytocin to accelerate delivery or placenta abruption, the systematic performance of episiotomy, prohibition of free movement or positions, and not allowing early skin-to-skin contact between the mother and the newborn or breastfeeding soon after the birth.

3.1.4. Availability of tools to collect data on women's experience of childbirth

Tools were identified as part of the desk-based research that offer more subjective insights into the perspective of women in relation to their experiences of childbirth. General tools which are used to collect data on women's experiences of childbirth are reported in some countries, but they are not specifically designed to detect obstetric violence. The tools allow for a more subjective perspective and analysis. Two tools are found in Finland and Hungary and one tool in Denmark, Ireland, Latvia, Portugal, Slovenia, Spain and Sweden.

In Denmark, the Nationwide Study of Patient Experiences for Women Giving Birth, (*Landsdækkende undersøgelse af patientoplevelser – fødende* – LUP) contains some information related to obstetric violence, such as giving informed consent to treatment, feeling safe and listened to, and staff being friendly and accommodating. Each question is answered on a five-point Likert scale.[97]

In Sweden, since December 2020, pregnant and new mothers can answer the Pregnancy Survey (*Graviditetsenkäten*). The survey was designed in close cooperation with the Pregnancy Register (*Graviditetsregistret*), the Swedish Society of Obstetrics and Gynaecology (SFOG), the Swedish Association of Midwives and the Rupture Register. The objective is to increase knowledge of the quality of care from women's perspective. There are no direct questions about obstetric violence. One question in this tool is whether women during pregnancy, childbirth and after birth have been treated with respect and dignity, where the answer might indicate obstetric violence.[98]

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ry (Veroszta et al. 2022); Ireland: Nagle et al. (2022); Italy: Ravaldi et al. (2018), Scandurra et al. (2021); Latvia: Procevska et al. (2023); Lithuania: Union of Motherhood Care (2021); the Netherlands: van der Pijl et al. (2022); Poland: Baranowska et al. (2019), Rodzić po Ludzku Foundation (2020), Rodzić po Ludzku Foundation (2021); Portugal: APDMGP (2019), APDMGP (2021); Slovenia: Čep (2020); Spain: El Parto es Nuestro (2016), Iglesias et al. (2019), Martinez Galliano et al. (2021), Mena-Tudela et al. (2020).

97 See: Centre for Patientinddragelse (2018).

98 See: https://skr.se/skr/halsasjukvard/vardochbehandling/forlossningsvardkvinnorshalsa/graviditetsenkaten.13922.html.

3.2. Groups of women at particular risk of obstetric violence

Obstetric violence can affect all women that are pregnant or giving birth, but certain groups of women can be targeted with greater severity. Recent studies establish that women with specific characteristics have a greater risk of being exposed to or of suffering violence during childbirth. This intersectional approach in studying childbirth has clearly highlighted that race/ethnicity (reflecting obstetric racism), age (notably young women), socioeconomic status (notably women with lower education levels), medical conditions and religion could be relevant factors in the care process.[99]

Research results identified in the Member States show that ethnicity, age and educational level are relevant factors. A younger age and low educational level are the factors most associated with obstetric violence in Italy[100] and in Belgium.[101] Ethnic minorities and migrant women are at a higher risk of obstetric violence, including Roma women in Romania and Slovakia;[102] Roma women and migrant women in Spain;[103] sub-Saharan African migrant women in France and Italy;[104] Afro-Brazilian women in Portugal;[105] migrant women in Belgium;[106] refugee and migrant women in Greece;[107] and Traveller women in Ireland.[108]

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 structural discrimination in the field of health in terms of being a woman, being an immigrant from Africa and the French overseas, and being Muslim.[109]

In the Netherlands, people belonging to an ethnic minority have a significantly increased risk of perinatal mortality.[110] Having a migration background is found to be a risk factor for obstetric violence in the Netherlands.[111] 'Obstetric racism' is reported as a distinct form of obstetric violence reported frequently by people of colour, mostly Black people (van der Waal et al. 2021; van der Waal forthcoming a, b).[112] Discrimination against pregnant women of colour is reported in the Netherlands in terms of being treated with assumptions, prejudice, systemic discrimination, negative communication and getting inferior care. 'Ceremonies of degradation' in the form of racist and paternalistic remarks have been noted.[113]

Obstetric racism contributes both to the frequency and severity of obstetric violence, and also affects birth outcomes. Seven dimensions of obstetric racism have been identified: diagnostic lapses; neglect, dismissiveness or disrespect; intentionally causing pain; coercion; 'ceremonies of degradation'; medical abuse;

99 See: Brigidi & Busquet-Gallego (2019) and El Kotni & Quagliariello (2021).

100 See: Ravaldi et al. (2018) and Scandurra et al. (2021).

101 See: Anissa et al. (2021).

102 See: LeMasters (2018) and Thominet et al. (2021).

103 See: Aguero (2019); and Brigidi (2022).

104 See: Sauvegrain (2021); El Kotni & Quagliariello (2021) and Quagliariello & Sauvergrain (2022).

105 See: Barata (2022).

106 See: Anissa et al. (2021).

107 See: Malakasis (2020) and Papadakaki et al. (2021).

108 See: Kavanagh (2018).

109 See: Rivenbark & Ichou (2020).

110 Achterberg et al. (2020).

111 Van der Pijl et al. (2022).

112 Van der Waal (*forthcoming a*)

113 Qreb (2021).

and 'racial reconnaissance'.[114]

A 2003 Slovakian study based on 230 interviews 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, with testimonials of numerous cases of forced and violent sterilisation of Roma women, physical and verbal attacks, racial discrimination in the provision of healthcare, misinformation given on health issues, and denial of access to health documentation.[115]

A 2017 Slovakian study included in-depth interviews with 38 Roma women living in eastern Slovakia on 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. They also said that they were not fully and adequately informed about their medical treatment. Some of the women described feeling neglected during labour and childbirth and that they were treated only after non-Roma patients. Most of the women felt humiliated at being placed in separate 'Roma-only rooms'.[116]

3.3. Impact of obstetric violence

3.3.1. Impact on victims of obstetric violence

A number of studies report on the consequences of obstetric violence for women in the Member States and beyond. The consequences on mental health – birth trauma and the increased risk of post-partum depression – were the most reported.[117] The physical and psychological suffering involved can affect the mother–child relationship and care in the first months of life, for example, breastfeeding and bonding.[118] In severe cases, it can be seen as 'birth trauma' or contribute to causing post-partum depression.[119] Violent experiences during childbirth can contribute to a loss of trust in the medical field, a decrease in care-seeking in future pregnancies and a decrease of the number of future children, particularly in middle- and low-income countries where maternal morbidity and mortality are issues.[120]

The consequences of having a baby are reported in terms of future choices. A Swedish study of 617 individuals found that 38 % of women who had a negative birth experience did not have additional children versus 17 % of women reporting a positive experience.[121] An Italian study found that 6 % of women listed abuse in childbirth as the main reason for refusing a second pregnancy.[122]

114 Davis et al. (2021).

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

116 Center for Reproductive Rights and Center for Civil and Human Rights (2017).

117 See: Olza-Fernández (2014); Martinez-Vázquez et al. (2022) and Scandurra et al. (2021).

118 See: Bossano et al. (2017) and Jarillo López et al. (2021).

119 See: Olza-Fernández (2014); Barbosa (2017); Oliveira (2017) and Martín-Badia et al. (2021).

120 See: Freedman & Krug (2014); Kujawski et al. (2015); Miller & Lalonde (2015); Bohren et al. (2015) and Savage & Castro (2017).

121 Smarandache (2016).

122 Ravaldi et al. (2018).

3.3.2. Impact on health professionals

Personnel in maternal healthcare are predominantly female. This is especially the case for midwifery, which is considered a typically female occupation. Qualitative studies in the Member States show professionals can suffer from being part of a system characterised by obstetric violence and that does not allow women to exercise their human rights in childbirth. Spanish midwives report being traumatised from witnessing obstetric violence or depressed from feeling like accomplices, and some leave their jobs because of trauma and burnout.[123] Conflicts between midwives' wishes and the norms of the health sector have been reported in the Netherlands.[124]

123 See: Olza-Fernández (2014); Barbosa (2017); Oliveira (2017) and Martín-Badia et al. (2021).

124 See: Fontein-Kuipers et al. (2018).

4. Policies and Initiatives

4.1. Introduction

This chapter addresses legislative approaches, institutional frameworks and types of initiatives found in Member States that address obstetric violence.

4.2. Legislative approaches and definitions in Member States' legislation

Three types of legislation are found across the Member States, which directly or indirectly regulate obstetric violence:

- Legal frameworks at a national or regional level clearly considering respectful maternity care, human rights or a physiological approach to childbirth
- Laws ensuring a minimum standard of care in delivery and birth
- National or regional laws targeting obstetric violence.

4.2.1. Legal frameworks on respectful maternity care

The existence of a general legal framework at the national or regional level which explicitly promotes respectful maternity care, human rights or a physiological approach to childbirth is considered as favourable driver for combating obstetric violence and for constructive political debate on the topic. However, only one country has a specific national law on childbirth, which explicitly addresses these perspectives. Portugal in 2019 enacted Law n. 110/2019, in which human rights in childbirth are explicitly stated.[125] There is no such legislation in other Member States.

4.2.2. Legal framework ensuring minimum standards of care

Patient safety, informed consent and the involvement of pregnant and birthing women in the patient safety process are important dimensions in combating obstetric violence. They focus attention on the minimum standards of care, which is invaluable.

The Council of European Union has defined patient safety as the absence of preventable harm to a patient during the healthcare process. [126] Article 9 states that 'Patients should be informed and empowered by involving them in the patient safety process. They should be informed of patient safety standards, best practices and/or safety measures in place and on how they can find accessible and comprehensible information on complaints and redress systems.' The 2012 Report from the European Commission to the Council on the basis of Member States' reports on implementation of Council Recommendation (2009/C 151/01) on patient safety found progress in the development of national policies on pa-

125 Diário da República n. 172/2019, Série I de 2019-09-09.

126 See: Council Recommendation 2009/C 151/01 on patient safety, including the prevention and control of healthcare associated infections: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX-:32009H0703(01)

tient safety and identified areas requiring further action, including the education and training of healthcare workers. [127]

Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare obliges Member States to ensure transparency in relation to quality and safety standards. [128] The Directive acknowledges 'the values of universality, access to good quality care, equity, and solidarity', which require that all 'patients are treated equitably on the basis of their healthcare needs' and which, according to 'the principles of free movement of persons within the internal market, non-discrimination', their rights are granted in all Member States.[129]

Most Member States have a general framework related to patients' rights acts or healthcare acts and health professionals' codes of conduct or ethics, providing norms and recommendations which are applicable to women giving birth and newborns. These documents advance minimum standards of care. Health acts and patients' rights acts available in most Member States clearly request informed consent for medical procedures. Despite the formal requirement of informed consent for medical interventions at birth, this is not always put into practice, as evident from the data presented in Section 3.1.3. Moreover, just the existence of laws and regulations in which consent is required is not sufficient. They must be fully accessible, effectively implemented and adequately elaborated. More research is needed to identify or better understand potential barriers to securing informed consent from women during delivery and childbirth.

4.2.3. Legislation targeting obstetric violence in Member States

No Member State has passed a national law directly addressing and defining obstetric violence. There are a number of national legislative developments under discussion in five Member States –Italy, Germany, Spain, France and Portugal – that are reported to address and in some instances define obstetric violence.

The only legal measure on obstetric violence enacted was reported from Spain at the regional level. Law No. 17/2020 enacted in Catalonia modifies Law 5/2008 on 'The rights of women to eradicate sexist violence'. It explicitly includes obstetric violence and the violation of sexual and reproductive rights as a form of gender-based violence and introduces in Article 4.d the following definition of obstetric violence:

> *Obstetric violence and violation of sexual and reproductive rights consists of 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 making decisions about their sexual practices and preferences and about their reproduction and the*

127 See the report from the Commission to the Council on the basis of Member States' reports on the implementation of the Council Recommendation (2009/C 151/01) on patient safety, including the prevention and control of healthcare associated infections: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52012DC0658

128 See: the Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32011L0024

129 See: the report from the Commission to the European parliament and the Council on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52018DC0651&rid=7

> *conditions in which it is carried out, in accordance with the assumptions included in specific legislation. It includes forced sterilisation, forced pregnancy, the impediment of abortion in legally established cases and difficulty in [obtaining] contraceptive methods, methods of prevention of sexually transmitted infections and HIV and assisted reproduction methods, as well as gynaecological and obstetric practices that do not respect the decisions, body, health and emotional processes of the woman.'*[130]

In addition, Regional Law 1/2022 of Equality of Women and Men of the Autonomous Community of the Basque Country mentions obstetric violence as a form of sexist violence, in Article 50, [131] and the Health Law 10/2014 of the autonomous community of Valencia refers to it.[132]

Table 3: Legislative developments that explicitly address obstetric violence

Country, Year

Italy, 2016

Law proposal/motion/resolution

Law proposal to the Chamber of Deputies titled 'Norms for the Protection of the Rights of Women and Newborns in Childbirth and Regulation for the Promotion of Physiological Birth'

Aim

Art. 1: to promote respect of the fundamental rights and personal dignity of the mother and the newborn; physiological childbirth; appropriateness of interventions in order to reduce the use of caesarean sections and all practices that harm the psycho-physical integrity of the woman, including episiotomy, ventouse (suction cup), forceps, artificial rupture of membranes, the Kristeller manoeuvre, induction of labour and any other practice to which the woman has not expressly consented; information on the freedom to choose the place of childbirth, including out-of-hospital birth.

Definition of obstetric violence

Art. 14 defines obstetric violence as acts or omissions performed by the doctor, midwife or other care provider aimed at taking from a woman her autonomy and dignity during childbirth. The following are acts of obstetric violence: denying appropriate care in cases of obstetric emergencies; forcing the woman to give birth in a lithotomy position; hindering or preventing early contact of the newborn with the mother without medical justification; hindering or preventing the physiological process of childbirth by the use of techniques to accelerate delivery without the express, free, informed and conscious consent of the woman; performing caesarean section in the absence of medical indication and without the express, free, informed and conscious consent of the woman; exposing the woman's body in violation of her personal dignity. Perpetrators of acts of obstetric violence shall be punished by imprisonment of two to four years, unless the act constitutes a more serious offence.

Status in legislative process

Discussion in Legislative Commission (2017). The law proposal is currently dormant.

130 See Law 17/20 on the rights of women to eradicate sexist violence. Núm. 8303 – 24.12.2020 3/15 Diario Oficial de la Generalitat de Catalunya: https://www.boe.es/eli/es-ct/l/2020/12/22/17

131 See: Ley 1/2022, de 3 de marzo, de segunda modificación de la Ley para la Igualdad de Mujeres y Hombres. https://www.boe.es/boe/dias/2022/03/28/pdfs/BOE-A-2022-4849.pdf

132 Health Law 10/2014 of the autonomous community of Valencia refers to it, as modified by regional Law 7/2021, of 29 December, on fiscal, administrative, financial and organisation measures of the regional government for 2022. https://www.boe.es/buscar/pdf/2015/BOE-A-2015-1239- consolidado.pdf

Country, Year

Germany, 2020

Law proposal/motion/resolution

Motion 19/19165 'Changing obstetrics and centring women and children' presented to the Parliament by the parliamentary group of the Green Party

Aim

Motion for a general reform of obstetrics including better quality of obstetrics, a better ratio between staff and mother, improving health standards

Definition of obstetric violence

Obstetric violence is mentioned, but not defined

Status in legislative process

Approved

Country, Year

Spain, 2021

Law proposal/motion/resolution

Law proposal. Project reform of the Law for sexual and reproductive health and voluntary interruption of pregnancy (Organic Law 2/2010)

Aim

Art. 1: to guarantee fundamental rights in the field of sexual and reproductive health, to regulate the conditions of voluntary termination of pregnancy and to establish corresponding obligations of the public authorities.

Definition of obstetric violence

The Law refers to adequate gynaecological and obstetric practices on the one hand (art 3.4) and to 'violence against women' in the reproductive field (art. 3.5) on the other. The latter is defined as: 'gender-based discrimination that violates integrity or self-determination of women in the field of sexual and reproductive health, their free choice about maternity, including behaviours included in Article 39 of the Agreement of European Council on prevention and the fight against gender-based violence and domestic violence.'

Status in legislative process

Approved by Minister's Council and pending to be passed by Parliament

Country, Year

France, 2020

Law proposal/motion/resolution

Draft resolution no. 3305

Aim

To invite the Government to make the fight against obstetric and gynaecological violence a priority and to implement the recommendations of the High Council for gender equality [*Haut conseil à l'égalité entre les femmes et les hommes*], who drafted a report on obstetric violence in 2018.

Definition of obstetric violence

The resolution refers to the High Council for gender equality definition of obstetric violence:

'gynaecological and obstetric violence refer to the most serious sexist acts. Sexist acts during gynaecological and obstetric monitoring are gestures, statements, practices and behaviours exerted on a patient (or omitted) by one or several members of care or medical staff. These acts 'take place in the history of gynaecological and obstetric medicine' and reflect 'the will to control the women's body (sexuality and ability to give birth)'. They are exerted by 'caregivers of every speciality, women and men, who do not necessarily intend to be abusive'. Sexist acts may take diverse forms, from the most trivial to the most serious. Six kinds of sexist acts that can occur during gynaecological or obstetric monitoring are defined: attitudes not considering the discomfort of the patient due to the intimate character of the consultation; sentences [words] bearing an appreciation of the sexuality, outfit, weight, willingness to have (or not have) a child, that refer to sexist injunction; sexist insults; acts (medical interventions, prescriptions, etc.) exerted in the absence of consent or that do not respect the choice or the demand of the patient; acts or refusals of acts that are not medically justified; sexual violence: sexual harassment, sexual aggression, rape.

Status in legislative process

Approved

Country, Year

Portugal, 2021

Law proposal/motion/resolution

Law proposal. Bill 912/XIV/2ª

Definition of obstetric violence

Art 4.º – 'shall be considered as obstetric violence any conduct relating to a woman during labour, birth or the puerperium which is carried out without her consent and which, being an act of physical or psychological violence, causes her unnecessary pain, harm or suffering or limits her power of choice and decision-making.

Status in legislative process

The dissolution of parliament in December 2021 interrupted the process of discussing and voting on the proposal.

Country, Year

Portugal, 2021

Law proposal/motion/resolution

Resolution of Parliament n. 181/2021

Aim

This recommends that the Government eliminates obstetric violence practices.

Definition of obstetric violence

The resolution recommends the elimination of obstetric violence practices, such as the Kristeller Manoeuvre and routine episiotomy from the Portuguese system and that an anonymous study be conducted to ascertain the extent of the problem of violence on pregnant and parturient women.

Status in legislative process

Approved

In a few Member States, specific acts of violence in reproductive health services, such as forced sterilisation or abortion, are addressed in particular laws or law proposals. In the Czech Republic, for example, legislation provides for a lump sum of money to go to persons sterilised without consent, stating: 'Sterilisation in violation of the law, for the purposes of this Act, means a health procedure preventing fertility, for the performance of which the woman did not give consent, or consent was given in such a violation of the legal regulations or under such circumstances that exclude or seriously violate the freedom of consent.[133]

4.3. Institutional framework

4.3.1. Overall framework

The institutional framework refers to various organisations, which address, or have the capacity to address, obstetric violence in accordance with their particular remit to their institutional mission. It includes both public and private institutions and civil society organisations.

Institutions, which by their mandate are key actors in addressing obstetric violence, are reported as playing such roles in all Member States. These encompass ministries of health, healthcare organisations, and scientific or health professional associations.

Two further types of organisations are reported to play a key role, specifically in raising awareness about obstetric violence and bringing about change in legislation and practices: observatories and civil society organisations.

4.3.2. Observatories on obstetric violence

Obstetric violence observatories are multidisciplinary bodies that aim to collect, analyse and disseminate data on a particular topic, and to engage in public debate at the political and community level. They are reported in five Member States:

- In Spain, the Observatory of Obstetric Violence (Observatorio de la Violencia Obstétrica) was established in 2014, initially within the non-profit organisation, Childbirth Is Ours (El Parto Es Nuestro)[134], becoming independent in 2019.
- In Italy, the Obstetric Violence Observatory Italy (Osservatorio sulla Violenza Ostetrica Italia) was established in 2016 by a group of mothers and midwives and activists, as a voluntary initiative.
- In France, the Observatory of gynaecological and obstetric violence was established in 2017, within the Research and Action Institute for Women's Health (Institut de Recherches et d'Actions pour la Santé des Femmes)[135], at the request of the then Secretary of State for Equality between Women and Men.
- In Greece, the Obstetric Violence Observatory of Greece (Παρατηρητήριο Μαιευτικής Βίας Ελλάδας) was established in 2018.
- In Portugal, the Obstetric Violence Observatory of Portugal (Observatório De Violência Obstétrica em Portugal) was established in 2021 as a non-profit

133 See: https://www.psp.cz/sqw/sbirka.sqw?cz=297&r=2021 Art. 1 § 3 2021

134 See website: www.elpartoesnuestro.es

135 See: https://afar.info/public/3056.

association of users and professionals of the health system, and since 2022 is acting as a multidisciplinary space for observing and publicly denouncing practices that constitute obstetric violence.

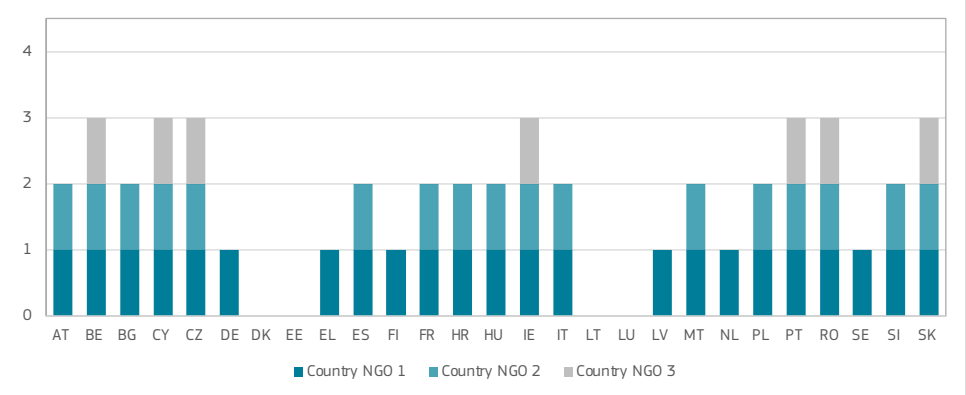
In 2016, the Spanish, Italian and French Observatories formed an international network, InterOVO, which links Observatories in the European Union Member States to Latin American Observatories in Argentina, Chile, Colombia, Brazil, Puerto Rico, Costa Rica, Uruguay and Paraguay, to exchange information, data and expertise.[136]

In Germany, Hungary, Ireland, Poland, Slovenia and Slovakia, observatories established for other purposes, have gathered information on obstetric violence.

4.3.3. Civil society organisations

Civil society organisations are reported to play valuable roles as promoters of initiatives to raise awareness on the topic of obstetric violence, and promote public debate on this issue. The SAAGE network identified 47 civil society organisations in 23 Member States that explicitly cover obstetric violence in their aims, by-laws and charters. They are led mostly by women and, in most of the cases, participants or activists are mothers, parents, health professionals and lawyers.

Figure 3: Distribution of civil society organisations explicitly addressing obstetric violence across the Member States, number per country



Source: SAAGE network, 2022.

Observatories on Obstetric Violence and civil society organisations are identified as fulfilling the useful role to convey data collected, particularly in relation to women's perspectives, to decision-makers.[137]

136 For example: InterOvo Statement, (InterOVO, 2016). https://www.elpartoesnuestro.es/sites/default/files/recursos/documents/interovo_statement_8th_march_2016.pdf.

137 See: Olza-Fernandez (2016); Brigidi & Ferreiro-Mediante (2018); Quattrocchi (2019); Gonzáles et al. (2020) and Gonzáles (2021).

4.4. Initiatives on obstetric violence

4.4.1. Institutional initiatives

Institutional and official initiatives, including from Ministries, observatories and healthcare organisations, addressing the issue of obstetric violence are reported in seven Member States (three in Belgium, two in Finland and Germany, and one each in Czechia, France, Ireland and Spain). A total of 11 initiatives are thus reported in these 7 countries. These are initiatives to recognise, prevent, report and denounce obstetric violence.

The types of institutional initiatives on obstetric violence include:

- Collection and dissemination of information on obstetric violence (e.g. Spain, Germany)
- Mechanisms to address the issue of obstetric violence (e.g. Czechia)
- Decisions of ombudspersons reaffirming the rights of mothers and children (Finland)
- A funding scheme for projects to combat obstetric violence (e.g. Belgium)
- A quality label for maternity care (e.g. France)
- A redress scheme for victims of forms of obstetric violence (e.g. Ireland).

Among them it is worth recalling briefly the following.

In Spain, the Catalan Society of Obstetrics and Gynaecology (Societat Catalana d'Obstetrícia i Ginecologia), set up the Working Group on Obstetric Violence and Gender Perspective in Health in 2022, to collect data and build consensus on the topic, through research, training and prevention actions, and awareness-raising initiatives.

In Germany, the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth launched 'Violence during childbirth – how are persons concerned and the public informed in a meaningful way? Results of an expert survey', a project of the Working Group on Women's Health in Medicine, Psychotherapy and Society (Arbeitskreis Frauengesundheit in Medizin, Psychotherapie und Gesellschaft e.V.) in 2022. Information was collected on the context for violence during childbirth as well as support structures, and issues of inadequate infrastructure and issues of accessibility to support in relation to diverse groups (young families, migrant women, refugee women, social work professionals, and family counselling centres). The report concluded that 'violence and disrespect during childbirth' is a major social, health and women's policy issue, and that information from public institutions is urgently needed to be disseminated to broad sections of the population and specific target groups.[138] Appropriate information materials for the target groups are to be developed.

In Czechia, the Working Group on Obstetrics of the Governmental Council for Equality of Men and Women was established in 2015, a multidisciplinary team consisting of doctors, midwives and experts in the field of health law, statistics, sociology and economics, to propose changes, recommendations, implementa-

138 See https://www.arbeitskreis-frauengesundheit.de/2005/08/19/stellungnahme-zum-praeventionsgesetzt/

tion mechanisms and procedures so that the system of pregnancy, childbirth and postpartum care will be safe and high-quality, and respect the right to the freedom of choice of parents to choose the method, circumstances and place of birth. In 2022, it was invited to participate in an ongoing process of setting the minimum standards of care in midwifery and gynaecology.

In Finland, the Parliamentary Ombudsperson of Finland in 2022 issued a Decision in relation to the COVID-19 restrictions in maternal wards. At that time, it was not allowed to have any support persons – whether the other parent or not – to accompany the mother in childbirth or maternal care. Responding to several complaints, the Parliamentary Ombudsperson stated that it was illegal and against the Constitution and human rights to restrict the attendance of support persons by default without considering the situations case by case. In contrast, a birthing mother should have by default the right to have a support person during childbirth or examinations during pregnancy if she wants. The Decision was based on the European Convention on Human Rights, Article 8.[139]

In Belgium, in the Wallonia region, a call for projects to prevent and combat gynaecological and obstetric violence was launched within the framework of the intra-Francophone plan to combat violence against women 2020–2024, by the Ministry of Women's Rights of the Wallonie-Bruxelles Government and the French Community Commission (Commission Communautaire Française), with a budget of EUR 300 000.[140]

In France, the National 'Maternys' label was launched in 2019. The French National College of French Gynaecologists and Obstetricians promoted the initiative to improve the quality of maternity care in hospitals. In April 2022, only 47 maternities (less than 10 %) were labelled 'well treating' maternities. Another 59 maternities had the 'Baby-Friendly Hospital Initiative' label of WHO and UNICEF.

In Ireland, the Surgical Symphysiotomy Ex-gratia Payment Scheme, was approved by the government in 2014 and implemented between 2014 and 2016 to address unconsented symphysiotomies carried out between 1944 and 1984. It identified obstetric violence as the medical appropriation of women's bodies and reproductive processes during childbirth, which causes a loss of autonomy and denies women their rights to make decisions about their bodies and sexuality. The redress scheme gave survivors just 20 days to apply, which was criticised as too short to allow women to access old medical records, and women could apply for one of three levels of compensation (EUR 50 000, EUR 100 000 and EUR 150 000), criticised as inadequate, depending on the proven severity of their injuries.[141]

139 Violation of the constitutional and human rights as right to self-determination and protection of private and family life. The Decision is available at: https://www.oikeusasiamies.fi/r/fi/ratkaisut/-/eoar/2463/2020

140 See: https://morreale.wallonie.be/home/presse--actualites/communiques-de-presse/presses/les-entites-francophones-lancent-un-appel-a-projets-commun-pour-prevenir-et-lutter-contre-les-violences-gynecologiques-et-obstetricales.html.

141 Delay & Sundstrom (2019).

4.4.2. Guidelines, protocols, position papers and communications

Guidelines, protocols, statements, position papers and communications covering or mentioning obstetric violence are reported in 11 Member States (3 in Portugal, 2 in Denmark, Finland, Germany and Hungary, 1 each in France, Italy, Luxembourg, Poland, Slovenia and Spain). Most of the documents were published by national umbrella organisations of gynaecologists, obstetricians or midwives, Ministries of Health and other healthcare institutions.

In France, the National Council of the Order of Midwives (Conseil National De L'Ordre des Sages-Femmes) published '2020: 20 Proposals for Women's Health' in 2020, in which obstetric violence is explicitly mentioned, using the definition of the High Council for Gender Equality.[142]

In Luxembourg, the Scientific Council of the Ministry of Health (Conseil scientifique, Ministère de la Santé) published 'Gynaecological and obstetric violence' (Violences gynécologiques et obstétricales) in 2021, indicating, on the basis of international definitions, what should be considered as obstetric violence, and making recommendations.[143]

In Germany, the Federal Ministry of Health published in 2019, 'Key issues paper: Immediate measures to strengthen obstetrics' (Eckpunktepapier Sofortmaßnahmen zur Stärkung der Geburtshilfe).[144] The German Society for Midwifery Science (Deutsche Gesellschaft für Hebammenwissenschaft) published in 2020 the statement 'Disrespect and Violence in Midwifery' (Respektlosigkeit und Gewalt in der Geburtshilfe) to make obstetric violence visible and raise public awareness, using a broad definition of obstetric violence that includes physical, psychological, sexual violence and humiliation and neglect.[145]

In Denmark, 'Recommendations for Maternity Care' ('Anbefalinger for Svangreomsorgen') were published in 2021 by the Danish Board of Health Services (Sundhedsstyrelsen),[146] exploring action to avoid the seven categories of disrespect and abuse in maternity care, as defined by Bowser and Hill.[147] Previously in 2013, the Danish Society for Obstetrics and Gynaecology published guidelines in relation to 'Previous traumatic obstetric birth experience'.

In Slovenia, the Chamber of Health and Midwifery Care of Slovenia (Zbornica zdravstvene in babiške nege Slovenije), the association of professional associations of nurses, midwives and nursing technicians, published the 'Professional guidelines for planned home birth' (Strokovne smernice za načrtovan porod na domu) to promote respectful birth in 2018.[148]

In Finland, in 2019 a review leaflet was published by the Nursing Research Foundation (Hotus), 'What kinds of experiences women describe in connection with

142 See: https://www.ordre-sages-femmes.fr/wp-content/uploads/2020/07/CONTRIBUTION-CNOSF-SEGUR.pdf.

143 See: https://conseil-scientifique.public.lu/fr/publications/perinat/violences-gynecologiques-et-obstetricales.html.

144 See: https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/Gesetze_und_Verordnungen/GuV/H/Eckpunktepapier_Sofortmassnahmen_Geburtshilfe.pdf.

145 See: https://www.dghwi.de/dghwi-positionspapier-respektlosigkeit-und-gewalt-in-der-geburtshilfe/.

146 See: https://www.sst.dk/-/media/Udgivelser/2021/Anbefalinger-svangreomsorgen/Svangreomsorg-2022-ny.ashx.

147 See Section 2.2: Bowser, D. and Hill, K. (2010).

148 See: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjahNiwh_r-AhXIEcAKHRRdAWcQFnoECAgQAQ&url=https%3A%2F%2Fwww.zbornica-zveza.si%2Fwp-content%2Fuploads%2F2020%2F01%2FSTROKOVNE-USMERITVE-ZA-NA%25C4%258CRTOVANI-POROD-DOMA.docx&usg=AOvVaw27Uv-cvUj9kdmIDN5SZsyS

traumatic childbirth?', and an official statement was published by the Finnish Medical Association 'Violence does not belong to childbirth' in relation to the #MeToo in Childbirth campaign.

In 2018, the Ministry of Health in Poland published an ordinance regarding organisational standards of perinatal care.[149]

In Hungary in 2019, the Hungarian Chamber of Doctors (A Magyar Orvosi Kamara közleménye) published a statement and in 2020, the Ministry of Human Capacities (Emberi Erőforrások Minisztériuma) proposed guidelines on family-friendly obstetric and infant care (Az Emberi Erőforrások Minisztériuma egészségügyi szakmai irányelv a családbarát alapelvekre épülő szülészeti és újszülött ellátásról).

In Portugal, the Nurses Professional Body, in 2021 published an opinion on the proposed law on obstetric violence.[150]

In Italy, Spain and Portugal, position papers have been published, against the use of the term 'violence' in relation to obstetric care, considering the term inappropriate as it implied intentionality to cause harm, by the Italian Association of Hospitalised Gynaecologists, the Spanish Society of Gynaecologists and Obstetrics and by the College of Gynaecology and Obstetrics of the Portuguese Medical Association.[151]

4.4.3. Legal cases

A total of 22 legal complaints, court cases or denunciations relating to obstetric violence were collected by SAAGE experts in 12 Member States. Most of these actions were successful and set examples for women encountering similar situations of obstetric violence in future. Moreover, some of them were brought before the European Court of Human Rights (ECHR) and the UN Committee on the Elimination of Discrimination Against Women (CEDAW), providing international jurisprudence.

149 Dz. U. poz. 1756.

150 Bill n.º 912/XIV/2.ª No. 912/XIV/2.

151 See in the order: AIGOI (2017), S.E.G.O. (2021), Colégio da Especialidade de Ginecologia e Obstetrícia (2021). For example, 'Opinion on strengthening the protection of women during pregnancy and childbirth through the criminalization of obstetric violence' ('Parecer sobre o reforço da proteção das mulheres na gravidez e parto através da criminalização da violência obstétrica'), see: https://ordemdosmedicos.pt/parecer-sobre-o-reforco-da-protecao-das-mulheres-na-gravidez-e-parto-atraves-da-criminalizacao-da-violencia-obstetrica/

Table 4: Legal cases relating to obstretic violence in the Member States

COUNTRY	LEGAL CASE FOCUS Reference	OUTCOME	YEAR DECISION
CZ	Oxytocin administration, episiotomy, disrespectful behaviour https://llp.cz/blog/zdravotnici-nere-spektovali-rodicku-a-provedli-zak-roky-bez-jejiho-souhlasu/	Dismissed	2021
	Involuntary sterilization before and shortly after 1989 https://is.muni.cz/th/bcobf/Paskova_Sandra_Porodnicke_nasili_tisk_final.pdf	Admitted	1948, shortly after 1989
EE	Refusal to register a child born at home. Case no 3-21-2840, Tallinn Administrative Court, 28.03.2022	Admitted	2022
	National ombudsperson initiative on restrictions for women giving birth https://www.oiguskantsler.ee/et/seisukohad/seisukoht/s%C3%BCnnitusabi-eesti-haiglates-eriolukorra-ajal.	The Chancellor of Justice recommended the Ministry of Social Affairs, hospitals, and other healthcare providers to find ways to alleviate the restrictions for women giving birth.	Spring 2020
ES	Episiotomy and post-traumatic stress. The complainant appealed to the Constitutional Court, which found the issue without constitutional relevance, and brought the case to the UN CEDAW Committee which adopted it in 2020. https://www.epe.es/es/sociedad/20220404/gallega-sufrio-violencia-obstetrica-onu-13472934	The UN CEDAW Committee recommended that Spain provide appropriate reparation to the complainant, including adequate financial compensation.	2022
	Kristeller manoeuvre https://www.rtve.es/television/20220502/he-sufrido-violencia-obstetrica-quiero-denunciar/2339121.shtml	Dismissed by local, national court, and now referred to UN CEDAW Committee.	2021
FI	Malpractice led to the death of the infant and removal of the mother's womb Virpin synnytys päättyi vauvan kuolemaan ja kohdun poistoon – 'Kätilö totesi, että onneksi sinulla on jo kolme lasta' | Paikalliset | Länsiväylä (lansivayla.fi)	After four years, the court decided that the midwife, the doctor and the hospital involved were responsible for malpractice.	2014
FR	Episiotomy without consent https://www.village-justice.com/articles/violences-gynecologiques-obstetricales-delicate-immixtion-droit-dans-les,40744.html.	Rejected on the ground that the act was responding to a medical imperative regarding the health and welfare of the baby. In addition, the complaint was considered 'abusive' and a fine of EUR 3 000 was imposed on the complainant.	2010

COUNTRY	LEGAL CASE FOCUS Reference	OUTCOME	YEAR DECISION
HR	National ombudsperson initiative on the untimely administration of anaesthesia/analgesia, inappropriate forms of communication, and application of Kristeller manoeuvre https://www.prs.hr/application/images/uploads/Godi%C5%A1nje_izvje%C5%A1%C4%87e_2021_FINAL.pdf	Failed to establish a violation of the provisions of the ethical codes of by responsible health-care professionals.	2021
	National ombudsperson initiative on a doctor's behaviour and form of communication, assessed as 'inappropriate', 'inadmissible' and 'unethical'. https://www.prs.hr/application/images/uploads/IZVJE%C5%A0%C4%86A/IZVJESCE_O_RADU_ZA_2019_Pravobra.pdf	The health inspection of the Ministry of Health found a failure in the management and monitoring of the birth and stated that the birth was not conducted in accordance with the rules of modern obstetric practice. Court proceedings were then initiated.	2019
HU	An obstetrician demanded gratuity from their patients. https://nepszava.hu/3092958_kovetelte-a-halapenzt-eliteltek-a-budapesti-szulesz-orvost	A detention period of one and a half years was imposed.	2020
	Women were examined in public in front of the department's medical and professional staff https://telex.hu/belfold/2021/01/08/bekescsaba-megyei-korhaz-szuleszet-hatosagi-intezkedes	Admitted by the ombudsperson	2021
IE	Symphysiotomy https://symphysiotomyireland.com/campaigning-for-access-to-the-law	Women who successfully took their case to the courts were awarded more than EUR 300 000.	2014
	Lack of abortion access https://Confidential-Maternal-Death-Enquiry-Report-2013-2015-151217-WebLinked.pdf	The Health Service Executive's (HSE) clinical review report into the death of a pregnant woman Savita Halappanavar in 2013 revealed multiple failures leading to her death from sepsis, including a failure to respond to the family's requests for abortion. Her husband settled his case against the HSE over her death for a substantial but undisclosed amount just before a hearing was due to start in the High Court.	2016

COUNTRY	LEGAL CASE FOCUS Reference	OUTCOME	YEAR DECISION
NL	Vaginal examination without consent https://tuchtrecht.overheid.nl/zoeken/resultaat/uitspraak/2022/ECLI_NL_TGZ-RAMS_2022_50?fbclid=IwAR0VevMquK-wOZ7Vel2KUjuWbkQrNehlvaHjjUkoCtPQdx-Nhss-U_p8gmW30	Regional disciplinary court for health in Amsterdam A2021/3342 declared the complaint was founded; imposed measures of reproach; and provided that this decision, which has become irrevocable, be made anonymous and published in the Dutch Official Gazette and made available for publication to the journals *Tijdschrift voor Gezondheidsrecht*, *Gezondheid Jurisprudence*, and *The Journal for Midwives.*	2022
	Lack of informed consent, lack of explanations about interventions, lack of respect for birth plan https://tuchtrecht.overheid.nl/zoeken/resultaat/uitspraak/2020/ECLI_NL_TGZR-GRO_2020_14	The Regional Disciplinary Court for Healthcare in Groningen declared the complaint well-founded and imposed a measure of warning.	2020
PL	Death of a women during labour https://www.pap.pl/aktualnosci/news%2C1062393%2Csmierc-37-latki-w-ciazy-blizniaczej-z-czestochowy-prokuratura-bada-sprawe	The investigation has been opened by the Regional Prosecutor's Office in Częstochowa as well as by the Patients' Rights Ombudsman. The autopsy performed just after the women's death confirmed that the cause of death was multi-organ failure. The Prosecutor decided that it was not conclusive in terms of the case and ordered another autopsy.	2022
	Denied access to anaesthesia and severe physical damages during the labour http://orzeczenia.gliwice.so.gov.pl/content/$N/151515000001503_III_Ca_001280_2015_Uz_2016-10-14_001	The Regional Court judge found the patient suffered harm, because, despite the hospital being able to offer the possibility of giving birth without pain, the complainant was prevented from getting access to epidural anaesthesia.	2016
PT	Episiotomy and corresponding suture without consent http://www.dgsi.pt/jsta.nsf/35fbbbf22e1bb1e-680256f8e003ea931/9e989c326795b-cbc80257a020034ae19?OpenDocument&ExpandSection=1&Highlight=0,ob-st%C3%A9trica	The ruling of the Supreme Court stated that episiotomy is an intervention that frequently occurs during labour and that depends on the judgement of need made by the professionals. There was a lack of sufficient proof of causality between the fact and the damage.	2012
	A newborn died a couple of hours after birth, in consequence of medical malpractice in handling of the suction cup. http://www.dgsi.pt/jstj.nsf/954f-0ce6ad9dd8b980256b5f-003fa814/2028519f107ac8ae-802577b5003a8527?OpenDocument	If the obstetrician proves that they were not negligent, they will not be liable for the damages, since there will be an inversion of the burden of proof, in this case.	2010

COUNTRY	LEGAL CASE FOCUS Reference	OUTCOME	YEAR DECISION
SK	'Improper provision of health care' or 'deficient medical records' http://odz.sk/institucie-ako-kulisy	Citizen, Democracy and Accountability, a civil society organisation, monitored complaints addressing human rights related to prenatal, obstetric and postnatal care. The remedy found 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 these rights violations.	2020–2021
	Forced and coercive sterilization of Roma women https://poradna-prava.sk/wp-content/uploads/2021/11/vakeras-zorales-speaking-out-roma-womens-experiences-in-reproductive-health-care-in-slovakia-1.pdf	The Slovak court awarded a Roma woman who had been sterilised in 1999 without her informed consent compensation for the full amount requested (EUR 16 596.95). The hospital was also ordered to formally apologise to her. Following the reasoning and approach of the ECHR, the court ultimately found that the woman's right to personal integrity had been violated. In November 2021, the Slovak government adopted a resolution, by which it condemned this practice and apologised for it.	2003

Source: SAAGE network, 2022.

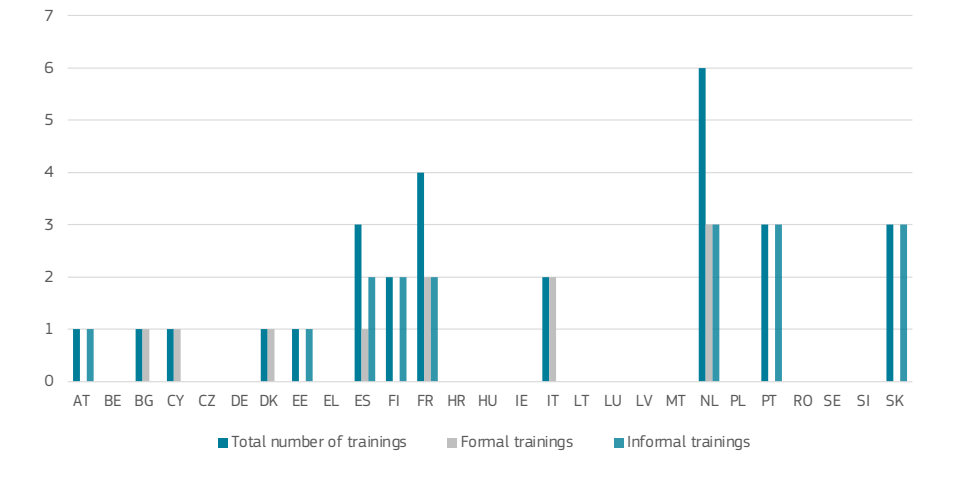
4.4.4. Healthcare providers training

Specific training for doctors, nurses and midwives explicitly addressing obstetric violence was reported in 12 Member States from 2017 to June 2022. In total, 28 trainings were reported, including academic and in-service training.

Formal and academic training curricula consist of courses, seminars and workshops at degree or post-graduate level organised by universities or other higher education institutions. These are one-off training events organised by health institutions (i.e. Ministry of Health or a Confederation of Gynaecologists or Midwives) as well as by civil society organisations and Observatories of Obstetric Violence.

Formal training is reported in 7 Member States and informal training is reported in 7 Member States. The Netherlands is the country with the most courses (6, with 3 formal and 3 informal), followed by France (4, with 2 formal and 2 informal), and then Spain (3, with 1 formal and 2 informal), Slovakia and Portugal (both 3, all informal), Finland and Italy (both 2, informal and formal respectively), Austria and Estonia (with 1 informal each) and Bulgaria, Cyprus and Denmark (1 formal each).

Figure 4: Distribution of health professional training on obstetric violence across the Member states, number per country

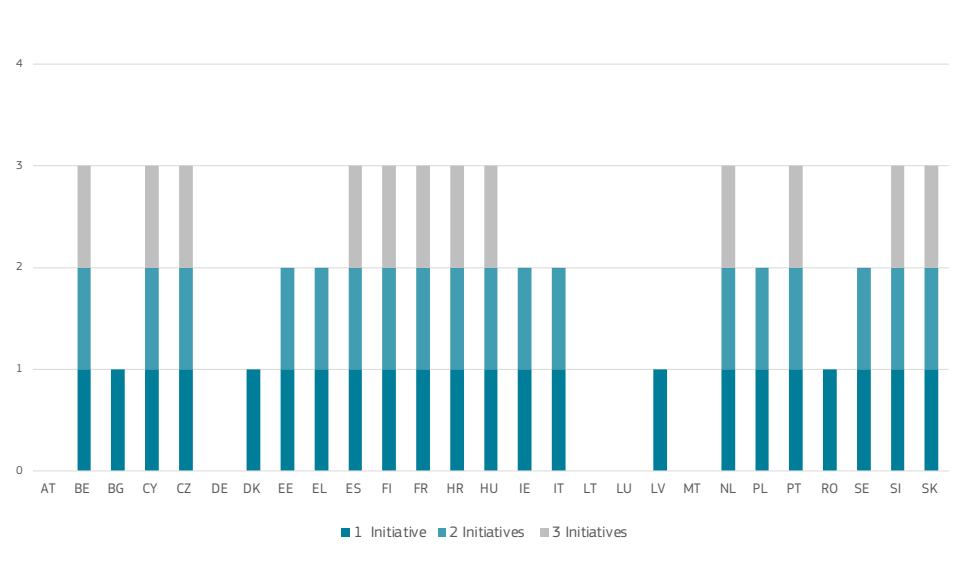


Source: SAAGE network, 2022.

4.4.5. Public awareness initiatives

Initiatives to raise public awareness and increase women's engagement in seeking to address obstetric violence are reported in most Member States. From 2017 to July 2022, 51 initiatives were reported, mostly organised at the national level by civil society organisations and Observatories of Obstetric Violence.

Figure 5: Distribution of observatory and civil society organisation initiatives across the Member States, number per country



Source: SAAGE network, 2022.

Social media and media campaigns are the initiatives most often reported. One example that involved various Member States was the 'BreakTheSilence' campaign. The production of documentaries and videos, the collection and reporting of data (databases, reports, documents, etc.) and the organisation of specific events including seminars and workshops, and citizen petitions are frequently reported.

Table 5: Type of public awareness initiatives

Type of initiatives	Number	%
SOCIAL MEDIA AND MEDIA CAMPAIGN	15	29.41 %
DOCUMENTARY/FILM	7	13.73 %
DATA COLLECTING/REPORTING/DRAFT	7	13.73 %
EVENTS (SEMINAR, WORKSHOP, PERFORMANCE, FESTIVAL)	7	13.73 %
CITIZEN PETITION, PROPOSAL	6	11.76 %
TESTIMONIAL ON WEB (STORYTELLING)	3	5.88 %
AWARENESS CAMPAIGN (NOT MEDIA)	2	3.92 %
CENTRE FOR VICTIMS/VICTIM-SUPPORT INITIATIVES	2	3.92 %
OTHER	2	3.92 %
TOTAL	51	100 %

Source: SAAGE network, 2022.

5. Case Studies on Progressing Change

5.1. Introduction

Case studies were undertaken in the third quarter of 2022 by national experts in France, the Netherlands, Slovakia and Spain to further inform the study and its recommendations. The four Member States were selected to represent a diversity of geographical locations, social and cultural contexts, obstetric practices and healthcare systems, and data availability.

The key purpose of the case studies was to inform policy and practice in responding to obstetric violence by identifying measures pursued in these Member States that mobilised the relevant stakeholders and held the potential to make a difference. The case studies are to inform the next steps following from this study.

The measures identified across the four Member States fall into and are explored under five broad categories with evident contributions to making progress on this issue:

- Legal frameworks, which allow some form of redress for some instances of obstetric violence, and establish societal and institutional norms that obstetric violence is not acceptable.
- Research and analysis, which gives visibility to the issue, enables understanding of the issue and its manifestations, and creates a body of evidence to inform the need for and nature of change required.
- Independent bodies, which give voice to victims of obstetric violence, protect and fulfil the rights of those subjected to obstetric violence, and bring professional expertise and standing to bear on the issue.
- Raising awareness, which serves to create sustained pressure on the responsible state institutions to take corrective action on this issue by uncovering the systemic violation of women's human rights during childbirth.
- Advocacy, which serves to fight for rights and raise awareness of the issue of obstetric violence.

5.2. France progressing change[152]

There is no legal definition and no specific law in relation to obstetric violence in France. However, the issue of consent does emerge in the ***legal framework***. According to the Kouchner Law of 4 March 2002,[153] free and informed consent must be obtained for any medical act by the health professional and this consent can be withdrawn at any time.

152 The case study for France was written by Virginie Rozée and Clémence Schantz.

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

While there is a large body of ***research and analysis*** in medicine, public health and social sciences on reproductive and sexual health, studies on conditions of and experiences during obstetric care and during childbirth are scarcer. Analytical approaches rarely examine violence, but the research does show that gynaecological consultations can be a place of violence, particularly around contraceptive injunctions.[154]

While there is no statistical data measuring the extent of obstetric violence, a National Perinatal Survey (Enquête Périnatale Nationale, EPN) has been regularly conducted on a regular basis since 1995 (1995, 1998, 2003, 2010, 2016, and 2021) with its results referenced in the European Perinatal Health report. The latest EPN was carried out in 2021 in all 480 French maternity hospitals (France metropolitan and overseas), including 6 birth centres, involving 13 404 women.[155] It introduced the concept of 'inappropriate care', which serves as a 'proxy' for the measurement of obstetric violence.

The 2021 EPN found 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. It highlighted 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 was stable at a rate of 21.4 % in 2021. The episiotomy rate has fallen sharply from 20.1 % in 2016 to 8.3 % in 2021, in line with national recommendations.

In relation to consent, the survey found 4.2 % of the women reported that the health professional(s) never asked for consent before performing vaginal touching 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 reported 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).

Anne Evrard, vice-president of CIANE (*Collectif interassociatif autour de la naissance*), reported, based on the testimonies of women and couples, experiences of infantilising, sexist, humiliating, denigrating, threatening and intimidating comments.[156]

Independent bodies include two recognised institutes that have addressed obstetric violence: the High Council for Equality between Women and Men (Haut Conseil à l'Égalité entre les femmes et les hommes); and the French National Academy of Medicine (Académie de médecine). They both published reports addressing obstetric violence in 2018 that serve as reference points:

- The French National Academy of Medicine[157] identified obstetric violence as any inappropriate or non-consensual medical act, posture or intervention, covering acts that do not comply with recommendations for clinical practice, as well as medically justified acts performed without prior information, without the patient's consent and/or with apparent brutality. Attitudes, behaviours

154 Fonquerne, L. (2021).

155 Le Ray et al. (2021).

156 Evrard (2020).

157 Académie de médecine; 2018.

and comments that do not respect women's dignity, decency and intimacy were cited and linked to the failure to account for pain during and after childbirth.

- The High Council for Equality between Women and Men report defined gynaecological and obstetric violence as 'the most serious sexist acts that can occur in the context of women's gynaecological and obstetric care' and identifies six types of such sexist acts.[158] The report made 26 recommendations grouped in 3 axes for action: Axis 1: Recognise the existence and extent of sexist acts, some of whom were victims of violence, as part of the follow-up gynaecology and obstetrics; Axis 2: Preventing sexist acts relating to gynaecological follow-up and obstetrics; and Axis 3: Improve and facilitate signalling of procedures and condemn practices sanctioned by law.

An observatory of gynaecological and obstetric violence (IRASF) was established in 2017. Civil society organisations that work on this issue, such as StopVOG, a French collective created in 2017 to denounce obstetric violence, have adopted the definition of obstetric violence of the High Council for Equality between Women and Men in their work.

Raising awareness encompasses media and cultural initiatives. The media addressed early denunciations and public debates on the issue, and this work was revived in the following years by the broadcasting of radio programmes and documentaries on the subject.[159] The first social scientific conference on the subject in France only took place in December 2019.[160]

Cultural products on obstetric violence and related issues have emerged. Comic strips and popular books have been published. In March 2016, blogger and illustrator Emma published *The story of my friend Cécile (L'histoire de ma copine*), in which she describes, with drawings, the conditions of her friend's childbirth, including the episiotomy that she had refused.[161] In 2017, the journalist Mélanie Déchalotte published *The black book of gynaecology* (*Le livre noir de la gynécologie).* [162] In 2018, Marie-Hélène Lahaye published her book *Childbirth, women deserve better* (*Accouchement, les femmes méritent mieux*).[163] Documentaries and short films were later produced, such as Ovidie's *You will give birth in pain* (*Tu enfanteras dans la douleur*) in 2019 and Nils Tavernier's *Let's listen to each other* (*Et si on s'écoutait*) in 2021.

Advocacy has played an important role in raising the issue of obstetric violence. Obstetric violence did not become a public and political issue in France until the mid-2010s, and was raised first in feminist activist circles[164], subsequently being disseminated through social networks. Public claims then appeared on social networks, in particular under the hashtag, #PayeTonUtérus, which was launched on 19 November 2014 and collected 7 000 comments in 24 hours.[165] That same year, Agnès Ledig, author and midwife, publicly denounced a practice called 'the

158 Bousquet et al. (2018),.

159 Salles (2021).

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

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

162 Déchalotte (2017).

163 Lahaye (2018).

164 Azcué and Tain (2021).

165 Bousquet et al. (2018) .

husband's stitch' ('*le point du mari*') (see Glossary).[166] Its prevalence is unknown and women are not aware of this practice which is performed without their consent.

In 2015, some 50 doctors, journalists and feminists published an opinion piece revealing and denouncing the practice of unnecessary vaginal and anal touching of patients under anaesthesia for a medical procedure.[167] These revelations provoked indignation and numerous testimonies on social networks, including those used to denounce mistreatment during gynaecological and obstetric care like *#PayeTonUterus, #PayeTonGyneco, #PayeTonAccouchement, #ViolencesObstétricales* and *#MonPost-partum.*[168] This raising of women's voices has contributed to obstetric violence being made more visible.[169]

5.3. The Netherlands progressing change[170]

While obstetric violence is not directly addressed in the ***legal framework*** of the Netherlands, the legal regulation of the medical treatment contract ('Wet wgbo'), under the Dutch Civil Code (DCC) as a form of assignment agreement, establishes a more indirect norm that does relate to the issue[171] and serves to strengthen the patient's legal position. In this, medical acts are understood to cover (paragraph 2):

- All operations – including examination and advice – directly related to a person and intended to cure them of an illness, to prevent them from developing an illness or to assess their state of health, or this obstetric assistance to provide.
- All other acts, directly related to a person, performed by a doctor or dentist in that capacity.
- Nursing and caring for the patient in this context and providing the material circumstances under which those actions can be performed directly for the benefit of the patient (clause 3).

The practitioner is legally obliged to inform the patient in advance about the treatment (Article 7:448 paragraph 1 DCC). This applies to the proposed research, the proposed treatment, developments regarding research, the treatment and the patient's state of health. If the patient so wishes, the information will be provided in writing. In practice, standard leaflets are often already provided or offered. The nature of the treatment, the risks, the chances, the alternative options for treatment and the state of the art must be discussed (paragraph 2).

The patient must give permission for the treatment (Art. 7:450 paragraph 1 DCC). For radical treatments, the practitioner will, if requested, record in writing the interventions for which permission has been given (Article 7:451 of the DCC). If the practitioner falls short in the treatment, the normal regime of failure to comply with agreements applies – in accordance with the layered structure of the Dutch Civil Code. The system of liability for non-compliance with obligations is a

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

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

168 Salles (2021).

169 Michel and Squires (2018).

170 The case study for the Netherlands was written by Rodante van der Waal and Marit van der Pijl.

171 This was incorporated in 1994 (in effect 1 April 1995, Stb. 1994, no. 845) in Afd. 5, Title 7, Book 7 of the Dutch Civil Code.

two-stage process, consisting of non-compliance and then attribution.

Research and analysis on issues of obstetric violence has seen the number of publications on obstetric violence in the Netherlands increasing since 2020. These publications involve both quantitative and qualitative studies.

A 2022 quantitative study on obstetric violence, based on a survey of 12 239 women in the Netherlands, found 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 %).[172] 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 not provided' (lack of communication, 20.9 %). Meanwhile, 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.

Four qualitative studies that specifically address 'obstetric violence' were published in recent years or are forthcoming.

- A qualitative content analysis of an activist campaign on obstetric violence, as referenced below in relation to the #breakthesilence campaign.[173]
- A cross-cultural thematic analysis between the Netherlands and South Africa on the effect of obstetric violence on student midwives and doctors.[174]
- 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.[175]
- An auto-ethnography (conducted in 2021–2022) on the epistemic nature of obstetric violence.[176]

The thematic analysis reported the types of obstetric violence most often experienced as:

- Unconsented and/or unwarranted and/or unwanted vaginal examinations
- 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)
- Physical violence, consisting of interventions without consent
- Penetrative violence, i.e. violence that is linked to, or reminiscent of, rape or sexual assault, such as (most listed) episiotomies, pelvic floor support (or 'pelvic massage') and vaginal examinations
- 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, and lying on one's back

172 Van der Pijl et al. (2022).
173 Van der Pijl et al. (2020).
174 Van der Waal et al. (2021).
175 Van der Waal et al. (forthcoming b).
176 Van Hasselt et al. (2023).

- Obstetric racism.

Midwives and obstetricians were mentioned by women in roughly equal numbers in these interviews, indicating that women experience disrespect and abuse throughout the maternity care system.[177]

Specific research is being undertaken on injustice in this field related to knowledge (epistemic injustice) and taking an autoethnographic approach (connecting personal experiences to wider cultural, political and social meanings and understandings). It established four forms of injustice in relation to obstetric violence:

- 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[178] (van Hasselt *forthcoming*).

Independent bodies that name and respond to 'obstetric violence' have played a role in responding to it. Two such foundations are:

- The Birth Movement (Geboortebeweging) is a foundation that brings together the main activists fighting for birth rights in the Netherlands. The term 'obstetric violence' is a regular feature of their discourse to describe the violation of human fundamental rights in childbirth.[179] Their work includes the provision of classes in midwifery and medical schools on 'care outside of regular guidelines and respectful maternity care' which reference 'obstetric violence'.
- The Foundation for Birth Trauma (*Stichting Bevallingstrauma*) 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.[180]

Awareness-raising on obstetric violence includes a campaign in which women were asked to share their experiences with maternity care on social media, initiated by the Birth Movement in 2016. This campaign is known as #rosesrevolution or #breakthesilence, and gained public and media attention, as a large number of women shared their stories.[181]

In 2020, a qualitative content analysis was undertaken to investigate the stories women shared in the #breakthesilence campaign to determine what types of disrespect and abuse were described in the stories[182], based on the typology of Bohren et al. (see Section 2.2), and to gain a more detailed understanding of women's experiences. In total, 438 stories were investigated. Situations of ineffective communication, loss of autonomy and lack of informed consent and con-

177 Van der Waal et al. (forthcoming b).

178 Van Hasselt et al. (forthcoming).

179 See: https://www.geboortebeweging.nl.

180 See: https://stichtingbevallingstrauma.nl/obstetrisch-geweld-2-0/.

181 See: https://www.facebook.com/media/set/?set=a.1149487385089171&type=3

182 Van der Pijl et al. (2020).

fidentiality were the most commonly mentioned. '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.

The media is another important actor in awareness-raising. There has been a focus on 'obstetric violence' through several media channels, for instance in the newspaper *The General Daily* (*Algemeen Dagblad*)[183] and on the public radio channel 1 (*NPO1*).[184] However, there are several media items in which topics clearly related to obstetric violence are discussed, but the term is not used, for example an item on RTL news.[185]

Other channels of communication, both cultural and professional, have included a focus on obstetric violence. Brainwash, a well-known cultural platform, has an article on obstetric violence on its website and is making a short information documentary on the term (*forthcoming*).[186] The midwifery platform, The Wise Voice (*Het Vroede geluid*), has a 'long read' on obstetric violence and published an informational video on the term.[187] The magazine, *Baby on the Way* (*Baby op komst*), for pregnant people published by midwives has a webpage on obstetric violence on their website.[188] The magazine for professional birth workers, *Early* (*vakblad Vroeg*), has an article on obstetric violence.[189]

Advocacy accompanying the various campaigns noted above is evident.

5.4. Slovakia progressing change[190]

Slovakia's ***legal framework*** does not include a comprehensive definition of and legislation on obstetric violence. However, there are provisions in a range of legislative acts that have relevance to preventing and sanctioning particular forms of obstetric violence. Specific crimes of obstetric violence, and some obligations to follow specific principles to prevent obstetric violence, are encompassed in the Criminal Code and in the Healthcare Act under the following articles:

Criminal Code Act. No. 300/2005 Coll.[191]

- §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 themself 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 them by law.

183 See: 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.

184 See: https://open.spotify.com/episode/2lmwGTpRq68WHPgKE622Ny.

185 See: https://www.rtlnieuws.nl/lifestyle/artikel/5201166/genoeggewegen2020-vrouwen-delen-hun-bevallingstrauma-ik-riep-hou-op-ik.

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

187 See: https://vimeo.com/640933816.

188 See: https://babyopkomst.nl/news/obstetrisch-geweld/.

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

190 The case study for Slovakia was written by Barbora Holubova.

191 See: https://www.zakonypreludi.sk/zz/2005-300.

- §157 Anyone who negligently injures the health of another by violating an important duty resulting from their employment, profession, position or function or imposed on them 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 and supplements to certain laws as amended by Act no. 41/2013).[192]

- §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 their 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
  f) Maintaining the confidentiality of all data related to their health condition, facts related to their 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.
- §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.

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

Research and analysis depend on and draw from the availability of administrative data and population-based quantitative data. The work of the National Centre of Health Promotion in gathering and presenting relevant administrative data is important in this regard. This data addresses some of the issues noted in Section 3.1.2 of this report as indicators for the prevalence and manifestation of obstetric violence. For example, complications during and after childbirth concerned 16 795 women giving birth in 2020 (29.9 % of the total number of women giving birth). The most common cases were episiotomies (9 864 women in labour) and tearing (rupture) of the perineum (6 261 women in labour) being

192 See; https://www.zakonypreludi.sk/zz/2004-576#

the most common instances.[193] The number of these procedures can also be seen to have increased in the last three years on the basis of earlier administrative data collected by the National Centre of Health Promotion.[194]

Population-based quantitative data on the prevalence of obstetric violence is available. However, this is only in a non-systematic way and based on non-randomised samples. An online survey was administered in 2020 for the Public Defender of Rights with a sample of 3 164 women who gave birth, where 48 % experienced an episiotomy and 28 % were not informed and did not consent to the intervention, and where 23.92 % of respondents said that the stitching of maternity injuries was an excruciating procedure.[195] Another online survey was completed in 2021 for the Citizen, Democracy and Accountability civil society organisation, wherein women disclosed various manifestations of obstetric violence, such as the refusal of the presence of an accompanying person during birth, lack of consent to medical interventions, the course of the labour delivery entirely determined by the hospital staff, and high rates of labour induction, episiotomy and the Kristeller manoeuvre (which is prohibited in Slovak hospitals).[196]

Independent bodies have played a role in this research work. The survey initiatives described were undertaken at the behest of a national human rights institution, Public Defender of Rights, and of a civil society organisation, Citizen Democracy and Accountability.

Awareness-raising processes include independent monitoring of women's experiences of obstetric violence. Broad monitoring of the current state of affairs in birthing facilities was conducted in 2015 and revealed several forms of obstetric violence.[197] Subsequent monitoring of the state of obstetrics in 2016, undertaken at the behest of the Citizen, Democracy and Accountability civil society organisation, revealed further serious violations of the human rights of women in connection with the provision of obstetric care. These violations were viewed as systemic.[198]

These processes of monitoring, disseminating the findings of monitoring, and advocacy for the elimination of obstetric violence, have been pursued by a gradually expanding range of stakeholders. Initially, it was exclusively civil society organisation that were involved and gradually the issue has been taken up by a wider range of bodies. This has included the creation of a network of obstetric violence experts and engagement with the issue by the National Human Rights Institution.

Another of these processes involves those in the field of arts and culture taking actions that promote public discussion on obstetric violence. Documentaries created by independent women filmmakers and viewed by thousands have captured instances of obstetric violence and contributed significantly to the beginning of discussions throughout society on the state of obstetrics. They had the effect that obstetric violence was no longer just a topic of women on internet forums or women's rights activists but a problem concerning children, families and health professionals.

The centrality of ***advocacy*** and of supporting advocacy is evident in the long-

193 NCZI, (National Centre of Heath Information) (2022).

194 NCZI, (National Centre of Heath Information) (2022).

195 Thominet et al. (2021).

196 Debrecéniová (2021a).

197 Babiaková et al. (2015).

198 Debrecéniová et al. (2016).

term struggle for justice for Roma women subjected to forced sterilisation. The engagement of a dedicated advocacy organisation with knowledge of international and national legal mechanisms has been key to the successes achieved. Litigation led to a change in legislation, a judgment of the European Court of Human Rights and an official apology from the Slovak Republic.

5.5. Spain progressing change[199]

Spain's ***legal framework*** does not explicitly mention the term 'obstetric violence' at the national level. However, some of its manifestations were addressed in the reform of the *National Organic Law 2/2010 of Sexual and Reproductive Health and Interruption of Pregnancy*, where:

- The protection and guarantee of sexual and reproductive rights in the gynaecological and obstetric field are 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 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.
- 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 practices that are contrary to what is established in Chapter II of the Law.

Law 41/2002 of Patient Autonomy guarantees the autonomy of women during childbirth.[200] Article 8 on Informed Consent states 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, Article 9 b) states that, in life-threatening situations where 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 the patient's relatives or close friends.

Research and analysis includes the work of the Ministry of Health in collecting indicators that give some insight into some of the indicators noted for obstetric violence (see Section 3.1.2). Their reports indicate that the episiotomy rate in

199 The case study for Spain was written by Stella Villarmea and Adela Recio Alcaide.

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the National Health Service is closer to quality standards, decreasing to 27.5 % in 2018, but other indicators such as induced births increased from 9.5 % in 1997 to 34.2 % in 2018.[201] Medical practices used to accelerate labour, such as oxytocin administration, amniotomies, Kristeller manoeuvres, episiotomies and instrumental births, are used much more frequently than necessary.[202]There is variation in obstetric interventions across the regions, as competences in health are transferred to the Autonomous Communities.

Independent studies are available. A recent quantitative study, for example, on the impact of the Strategy for Normal Birth Care (Estrategia de Atención al Parto Normal), of 2007, on caesarean section rates and perinatal mortality found that updating clinical practices, empowering women in making their decisions, training professionals and promoting good practices of natural delivery can significantly reduce the rate of caesarean sections.[203]

A survey of 17 541 women in 2020 on obstetric violence found that 38.3 % of women reported having experienced it while giving birth or in the post-partum period.[204] 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 % that they were criticised for their behaviour with ironic or discrediting remarks; 31.4 % had been treated with nicknames or childish diminutives; 48 % indicated they found it impossible to resolve their doubts or 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. A total of 83.4 % were not requested to provide informed consent.

Research and analysis categorising manifestations of obstetric violence found the deprivation of the right to autonomy during the stay at a healthcare facility,[205] non-evidence-based clinical practices,[206] and other manifestations of disrespect towards women in labour,[207] such as verbal abuse or lack of facilitating intimacy and contact between mother and child.

Independent bodies addressing this issue include the association 'Milky Way' (Vía Láctea) founded in 1987, and 'Childbirth is Ours' (El Parto es Nuestro) founded in 2003 in response to the scale and harm of obstetric violence. Civil mobilisation on obstetric care started in Spain in the 2000s and has had considerable media and public policy impact.[208]

The Observatory of Obstetric Violence (Observatorio de la Violencia Obstétrica) was established in 2014 within a civil society organisation and became an independent entity in 2019. The Women's Health Observatory coordinated a public debate that involved all relevant stakeholders in response to the initiative of the Ministry of Health to develop the *Strategy for Normal Birth Care.*[209] The *Strate-*

201 Ministerio de Sanidad (2022).

202 Ministerio de Sanidad. (2012).

203 Recio Alcaide and Arranz (2022).

204 Mena-Tudela et al. (2020).

205 See: Mena-Tudela et al. (2020); Fernández Guillén (2018); OVO (2016) and Brigidi & Busquets-Gallego (2019).

206 See: Fernández Guillén (2020); Ministerio de Sanidad (2012); Ministerio de Sanidad (2021); Farrés et al. (2021).

207 See: Fernández Guillén (2015).

208 Villarmea et al. (2016).

209 Ministerio de Sanidad (2007).

gy was a response to a social, professional and health administration demand, motivated by the progressive medicalisation of the process and the increase of unnecessary and unjustified interventions in a physiological process with repercussions on health.

There are tensions between independent bodies.[210] Some health practitioners and professional bodies resist the focus on obstetric violence and deny the need for policy measures to address the issue of obstetric violence, including the Spanish Society of Gynaecology and Obstetrics and the General Council of Official Colleges of Physicians. The tension emerges with those civil society organisations seeking such change, as well as with other professional bodies, such as the Federation of Associations of Midwives of Spain, the Catalan Society of Obstetrics and Gynaecology, the Council of Medical Associations of Catalonia, and other medical, nursing or psychology student associations (AEEE, CEP-PIE and CEEM).[211]

A range of ***awareness-raising*** processes that focus on obstetric violence include significant awareness-raising work in relation to rights in childbirth by women's organisations, such as 'Childbirth is Ours' ('El Parto es Nuestro) and the 'Observatory of Obstetric Violence' (Observatorio de Violencia Obstétrica). This has encouraged several women to take legal action to denounce mistreatment received during childbirth. In recent years, birth activism has placed obstetric violence on the feminist and equality policy agenda, and there has been a heated debate raised in the media regarding the inclusion of obstetric violence in national legislation[212] and in regional legislation, such as of the Autonomous Communities of Valencia[213] and La Rioja.[214]

Advocacy is evident in that the only two Resolutions adopted by the UN CEDAW Committee regarding victims of obstetric violence involved Spain as the State party.[215] In both cases, the CEDAW Committee recalled the obligation of the State to abolish customs and practices that constitute discrimination against women and considered that stereotyping affects the right of women to be protected against obstetric violence.

In 2020, on the initiative of Childbirth is Ours and the Observatory of Obstetric Violence, meetings were convened between women's associations and the Ministry of Equality, seeking to ensure Spain complied with recommendations on obstetric violence from the UN and WHO.[216] While the Ministry of Equality then announced the inclusion of the term 'obstetric violence' in the text of the reform of the *National Organic Law 2/2010*, the term was excluded from the final text due to opposition from professional bodies and the Ministries of Health and Justice.

Activist campaigns are another feature, such as the Childbirth is Ours campaigns: *Stop Kristeller: A Matter of Gravity,*[217] and *United at NICU: Do Not Separate Us, A Matter of Health.*[218]

210 El Salto (2021).

211 El Parto es Nuestro (2022a).

212 El Diario (2022c).

213 El Diario (2021b).

214 Nuevecuatrouno (2022).

215 *S.F.M. v. Spain* in 2020 (CEDAW 2020), and *N.A.E. v. Spain* in 2022 (CEDAW 2022).

216 El Parto es Nuestro (2020a).

217 See: https://www.elpartoesnuestro.es/informacion/campanas/campana-stop-kristeller-cuestion-de-gravedad

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

6. Conclusions and Recommendations

6.1. Conclusions

The concept of obstetric violence has not been defined and explicitly addressed in European or national Member State level legislation. The absence of an agreed definition for the issue around which legal norms could be established and on the basis of which standards of policy and practice could be framed is a problem.

The term itself is a subject for debate and disagreement, in particular the terminology of 'violence' with some institutions putting forward a terminology of 'abuse', 'disrespect' and 'mistreatment'. This position is critiqued for failing to be cognisant of the power structures and gender inequalities that frame any such treatment.

This lack of definition of obstetric violence is reflected in the absence of an agreed framework for the spectrum of relevant dimensions. Two broad approaches are evident: one based on categories of disrespect and abuse, and the other classifying obstetric violence in more structural terms. The absence on an agreed framework through which to analyse, understand and make provisions in relation to the issue of obstetric violence impedes an effective and uniform response to this issue across the Member States. Any such framework would usefully address the issue of obstetric violence as an issue of gender-based violence, a form of institutional violence, and a violation of human rights.

The systematic collection of data on obstetric violence at the EU level is limited. The Euro-Peristat initiative has, however, played a valuable role in monitoring a number of indicators across a wide range of Member States. This work establishes that obstetric violence is a significant issue across the Member States, particularly in the high rates of caesarean sections across all Member States and the high rates of vaginal instrumental deliveries, induced labour and episiotomies on women who delivered vaginally in a number of Member States. A high incidence of such caesarean sections, induced labour and episiotomies can signal forms of hyper-medicalisation or abuse of medicalisation that encompasses obstetric violence.

Qualitative research on obstetric violence within individual Member States has identified the prevalence of certain forms of obstetric violence, including lack of informed consent and non-consented-to care; verbal and physical abuse; lack of communication; and an over-medicalisation of care combined with clinical practices performed that are not based on evidence-based medicine. Across these studies, between 21 % and 81 % of the surveyed women who had given birth had experienced one or more forms of obstetric violence. There is, however, a lack of national data and standardised tools to measure the prevalence of obstetric violence across the Member States. Despite the shortcomings in evidence, the available data does convincingly demonstrate that obstetric violence is a preva-

lent and harmful issue across EU Member States.

The spectrum of developments found across the Member States that seek to address obstetric violence are illustrative of what is required to more effectively address this phenomenon. These encompass legal frameworks, research and analysis, and mandated institutions, alongside a range of initiatives including institutional initiatives, guidance documents, legal casework, training for health professionals, awareness-raising, and advocacy.

However, it is clear from the data on the levels of obstetric violence that a more comprehensive spread of such developments is required across the Member States and a more strategic deployment and interaction of these elements is required for impact. In particular, the legal framework explicitly addressing obstetric violence is found to be particularly under-developed, though the legal regulation of minimum standards of care can play a role in this regard. Further research is needed to strengthen an underpinning strategy for these developments and to inform and improve their design and deployment.

6.2. Recommendations

At the European Union level, it is recommended that the European Commission:

- Facilitates exchanges among Member States on the issue of obstetric violence, including through Mutual Learning Seminars with Member States, in particular by:
  - Sharing information on developments and good practice in addressing obstetric violence at the Member State level and developing models for good practice for the various elements required to address obstetric violence;
  - Promoting dialogue and peer support on responding to the issue of obstetric violence between the stakeholders and across the Member States, strengthening commitment and expertise.
- Mandates the European Institute for Gender Equality ("EIGE") to develop a set of quantitative and qualitative indicators to measure the prevalence and manifestation of obstetric violence.

Through relevant EU financing programmes, funds projects on obstetric violence, including with the purpose to:

- Reviewing the legal and policy frameworks in Member States and at the different governance levels to combat obstetric violence, including in particular, the minimum standards of care in maternity and perinatal care, in order to identify a standard for such a legal framework, and to flag possible gaps in the legal frameworks of Member States;
- Conducting policy research in the field to further explore the causes of obstetric violence, its manifestations and consequences, and the quality and impacts of the policy initiatives adopted to respond to this issue;
- Exploring available avenues for patients to report cases of obstetric violence and seek redress.

At the Member State level, it is recommended that the Member States and their relevant institutions:

- Review their legal framework in place and ensure it is adequate to address obstetric violence, establish norms on the issue, and provide for redress.
- Develop and ensure implementation of protocols and guidelines for healthcare institutions and professionals to prevent and eliminate obstetric violence.
- Promote, support and implement programmes of awareness-raising and training for relevant healthcare professionals, including midwives, gynaecologists, neonatologists, nurses and paediatricians, health system personnel, staff of private and public health organisations providing care, and students. This awareness and training would update their knowledge, promote maternity and childbirth standards, and inform their capacity to meet these standards consistently.
- Promote and resource evidence-based academic studies and policy research in the field to further explore, within a structural framework, the causes of obstetric violence, its manifestations and impact, and the impacts of the policy initiatives adopted to respond to this issue.
- Advance the development and implementation of national monitoring systems, based on EIGE definition of obstetric violence, with a view to tracking incidence and forms of obstetric violence, and to monitoring changes over time.
- Promote, support and resource civil society initiatives to raise awareness of the issue of obstetric violence, to advocate for change on this issue, to inform women of their rights in this regard, and to provide support to women whoseek to exercise these rights.

7. Glossary

Acceleration of labour	The speeding up of labour by the use of drugs, usually via a synthetic oxytocin drip.
Caesarean section	It is a surgical procedure to deliver a baby through an incision in the abdominal and uterine walls.
Dilation/Dilatation	In the first stage of labour, the cervix, or neck of the womb, gradually opens up to make space for the baby. It needs to open to approximately 10 centimetres before the baby's head can pass through. This process is called dilation of the cervix.
Epidural	An injection of local anaesthetic into the lower back, given for pain relief during labour. This can be topped up via a catheter (a thin tube) that is left in place during labour. For most women, an epidural takes away all the pain of contractions.
Episiotomy	A cut made in the mother's perineum (the area between the vagina and anus) to allow the baby to be born more quickly and prevent tearing.
Forceps	A pair of hollow blades, rather like large salad servers, which are placed on either side of the baby's head to assist with the birth. When this happens, it is known as a forceps delivery.
Haloperidol	A powerful antipsychotic administered to a parturient to help to relax. There is no scientific basis for its use and it is dangerous for the child.
Husband's stitch	It is a surgical procedure in which one or more additional sutures than necessary are used to repair a woman's perineum after it has been torn or cut during childbirth. The claimed purpose is to tighten the opening of the vagina and thereby enhance the pleasure of her male sex partner during penetrative intercourse.
Induction	Starting the labour artificially.
Informed consent	It is the intentional communication process where benefits, risks and alternatives of a treatment or procedure are disclosed, allowing independent acceptance or rejection by patients.
Kristeller manoeuvre	It is defined as a manual pressure of the fundus of the uterus towards the birth canal. Also called fundal pressure, it is used to expedite birth of the baby during the second stage of labour. Fundal pressure has also been applied using an inflatable belt.
Labour	The process of childbirth. There are four stages of labour. The first stage includes three phases: early contractions are usually irregular, active contractions become strong and regular, transition when the cervix will open completely. The second stage lasts through the birth, with the baby travelling down and out of the birth canal. The third stage is after the birth, when the placenta is delivered. The fourth stage is the first few hours after the birth.
Lithotomy position	A position used for assisted deliveries, where the mother lies supine with her legs raised and apart, supported by stirrups.

Obstetrics	The medical discipline dedicated to pregnancy, childbirth and puerperium.
Oxytocin	The hormone secreted by women when they are in labour which stimulates labour contractions. The same hormone also stimulates milk flow from the breasts by contracting the muscle fibres in the milk ducts.
Perineum	The area of skin between the vagina and anus.
Placenta	The organ that develops in the uterus during pregnancy to transfer nourishment and oxygen to the baby from the mother's system, and to take away the baby's waste matter.
Postnatal	After the birth. Relates to the 28-day period following giving birth.
Postpartum	Relating to the period of a few days after the birth.
Prostaglandin	A natural substance used in pessaries to soften the cervix and stimulate the start of labour.
Rooming in	Most maternity units now recommend that babies stay with their mothers 24 hours a day. This helps with feeding and bonding. It also reduces the risk of infection.
Skin-to-skin	Skin-to-skin contact with a baby after birth (the baby is dried and put straight onto the adult's chest).
Symphysiotomy	It is an operation in which the fibres of the pubic symphysis are partially divided to allow separation of the joint and thus enlargement of the pelvic dimensions during childbirth.
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.
Ventouse/suction cup	This is the name given to a method of vacuum extraction to help the baby be born at the end of the labour, either if the mother is very tired or if the baby has become distressed.

Note: Definitions come from the Cambridge Dictionary, https://dictionary.cambridge.org/.

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