Annual Seminar report

Obstetric Violence: Towards New Understanding and Responses

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ABOUT

This report summarises the SAAGE hybrid seminar held on 6 November 2023 in Brussels.

Fondazione Giacomo Brodolini S.r.l. SB (FGB SRL SB) is an Italian independent research centre inspired by the principles of labour and social inclusion, gender equality, cultural diversity and respect for fundamental human rights, welfare promotion, territorial cohesion, sustainability, and technological innovation to boost economic growth, attention to the environment, access to employment through new skills, and participation for local development.

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TABLE OF CONTENTS

INTRODUCTION

Karen Vandekerckhove, Head of Unit, Gender Equality Unit of DG JUST, European Commission, opened the seminar with an introduction to the current perspectives of the European Commission in this policy field.

The issue of obstetric violence is a sensitive issue. While it has lacked attention for too long, and continues to lack adequate attention, it is now more generally recognised as an issue. It remains an issue that is under-reported, however. This can be because it is overlooked, considered to be no more than 'how things are', or rendered a subject of shame.

This issue of obstetric violence is exacerbated in contexts of intersectionality. This is seen in the experiences of disabled women, Black and minority ethnic women, including Roma women, and non-heterosexual and non-CIS-gender women.

In the policy arena, the Commission is committed, with some priority, to tackling gender-based violence and supporting victims of gender-based violence. This is a central theme under the Gender Equality Strategy 2020-2025. This focus on gender-based violence is why the reports on the specific issue of obstetric violence, that are a focus for this seminar, were commissioned through the SAAGE network.

1. OBSTETRIC VIOLENCE: AN EU-WIDE PERSPECTIVE

1.1 Presentations

Dr. Patrizia Quattrocchi, Professor of Cultural Anthropology and Senior Researcher in Medical Anthropology and Reproductive Health at the University of Udine, presented on Obstetric Violence in the EU: the issue, the situation, actions taken, and recommendations.

There is a growing recognition for the issue of and the terminology for obstetric violence. The terminology is important for acknowledging this issue as a form of structural and systemic violence, rather than a product of a single provider's intentional behaviour during childbirth, or being an accusation against the medical profession of being violent.

In moving towards a definition, there needs to be recognition that this is a specific form of violence that combines gender based violence and institutional violence, which is expressed in different types of abusive and disrespectful care, action or omission, that cause harm to women, and are generated in public and private health services, being inflicted by providers (intentionally or not), but in particular by health systems as a whole, and which is a violation of human rights, including the rights to health and reproductive autonomy.

Data on prevalence of obstetric violence is growing in the EU Member States as well as qualitative data on women's and providers' perspectives and experiences. This data is coming from academic research and civil society organisation research, rather than governmental bodies. Despite a lack of specific indicators, a number of quantitative indicators on abuse of medicalisation and interventions are monitored across the EU, where a high incidence of such indicators can signal obstetric violence. All women are at risk of obstetric violence in EU Member States, but ethnic minority women, migrant women, women of a younger age, and women of low educational level are at higher risk.

Initiatives are being taken on the issue, but there is a need for further action across the Member States. National legal frameworks which explicitly promote respectful maternity care, human rights or physiological approach are lacking. Obstetric violence observatories (in five Member States) and civil society organisations make a key contribution. Initiatives to recognise, prevent, report and condemn obstetric violence are found,

including from Ministries and healthcare organisations (in seven Member States). Guidelines and protocols have been developed (in eleven Member States). While most health professional training (academic or in-service) does not include a gender and human rights perspective, specific training events for health professionals explicitly addressing obstetric violence are found (in twelve Member States),

It is recommended that the European Commission would convene a high-level group on the issue and pursue and resource a specific programme of work on the issue. It is recommended that Member States: review the adequacy of the legal framework in place; develop and ensure implementation of protocols and guidelines for health care institutions and healthcare professionals to prevent and eliminate this issue; promote, support and implement awareness programmes and training for healthcare professionals on this issue; promote and resource academic studies and policy research on the issue; and promote, support and resource civil society initiatives on the issue.

Overall, there is a need for alliance building to address this issue that would be multi-disciplinary, involve institutions and civil society organisations, and that would include women and healthcare professionals.

1.2 Plenary Discussion

The opposition of some health professionals in some Member States to a focus on this topic, was noted as being based on arguments of resources availability and of healthcare systems being in crisis. Adding further burdens on healthcare systems by promoting standards could mean losing healthcare professionals to other jurisdictions. It was emphasised that this captures the structural nature of this issue. The system must change to address this issue.

There are other forms of violence in the health sector, it was suggested, meaning this issue is not confined to obstetrics and gynaecology. It happens to other patients. There is a specificity to obstetric violence, it was noted, in that the subject is women. It is gender-based, rooted in cultural and social representations of women's role and women's bodies. It encompasses a cultural challenge, in terms of the way people think, as much as it reflects a healthcare problem.

There is a challenge, it was mentioned, to precisely identify what is an act of obstetric violence, and to measure the issue of obstetric violence with adequate indicators. An evidence base is required in a profession such as medicine that is evidence-based. It was noted that there are tools available. Indices of mistreatment have been developed. Research frameworks have been established and data gathered based on these. The WHO has played a central role in this. The challenge is more to find consensus around these tools. In this, quantitative and qualitative tools are needed, as obstetric violence is a subjective experience.

The term obstetric violence, it was suggested, can lead to a negative reaction. It is a provocative word. People react against the suggestion that they are being violent. But, it was noted, the provider is not being accused of being violent, the problems is with the system. This is about the nature and rates of interventions and the significant differences in these rates across institutions and across jurisdictions. It is important for people to look at the term in this way and take up this challenge to address its systemic nature.

2. OBSTETRIC VIOLENCE: THE MEMBER-STATE LEVEL

2.1 Presentations

Dr. Virginie Rozée, Researcher, Institut National d'Études Démographiques (INED), presented a case study for France: evidence, initiative and recommendations

The French healthcare system can be seen to encourage obstetric violence, in a context of the bio-medicalisation of bodies and institutionalisation of care, and of a sector in crisis for lack of public funds and being driven by the profit rationale. Women's reproductive bodies and health are governed by bio-medicalisation and subjected to biopower in one of the most bio-medicalised health systems in the EU. The shortage of staff and equipment alongside deteriorating working conditions are difficult to reconcile with humane and personalised medical care.

Two main civil society organisations work on this issue, one supports women and families who have experienced obstetric violence, the other engages in public denunciations of obstetric violence. There are an increasing number of denunciations and complaints of obstetric violence, but no official condemnation of this issue.

At a government and institutional level: the birth plan was introduced (2005), but there has been no or low compliance; the Secretary of State for Gender Equality commissioned a report from the High Council for Equality (2018), that defined obstetric violence and identified the forms that it takes, but has not led to concrete action; the 'Maternys' label was introduced to underpin good practice (2019), but has been strongly criticised; the early Postnatal Interview (2022) was introduced, which is too recent to assess impact; and the Prime Minister referred an egregious case to the National Consultative Ethics Committee (2022).

There is a need to: expand the range of birthing options; implement national campaigns to inform women of their sexual and reproductive rights; provide for legal recognition of violence when consent has not been sought and when the patient's choice and integrity have not been respected; and support academic research on obstetric violence.

Dr. Marit van der Pijl, Department of Midwifery Science, Amsterdam Medical University Centre, presented a case study for the Netherlands: evidence, initiative and recommendations.

The Dutch maternity care system includes primary midwife-led care and obstetrician led care. 14% of births take place at home, 13% in a birth centre or hospital with a primary care midwife, and 73% in a hospital under obstetrician-led care.

There has been growing recognition of obstetric violence. This started with the #breakthesilence campaign (2016), organised by the Birth Movement. In this, women were invited to write their negative experience with maternity care and share it online. Research was undertaken to analyse these responses. Further research on the issue of obstetric violence was undertaken in an online national survey of birth experiences. In this, obstetric violence was reported with frequency, with consent frequently not being sought for interventions. The perspective of the care providers is under-researched and needs more attention.

Initiatives taken include the work of the Birth Movement in supporting women who experience obstetric violence or are limited in their choices during pregnancy and birth, through a support group on Facebook, and help-line. There are training courses and masterclasses for care providers that explicitly mention and inform about obstetric violence and training courses that are focused on respectful care and preventing mental trauma. There is increasing attention on obstetric violence in midwifery education, however this is still limited.

There is a guideline on maternity care outside the system, for women that have specific wishes that do not

fit with the current guidelines, which establish that attention and respect for the wishes of the patient, without judgement is important. The goal is to inform pregnant women, with the final decision on care being theirs.

There is a need to: invest in and support autonomous primary midwife-led care and continuity of care, as this offers continuity of care and empowers women to be in charge of their care, and enables them to have choice; build awareness and recognition of obstetric violence, in institutions, through guidelines and policy, to tackle authoritarian structures, address the high workload of care providers, and give particular attention to informed consent; and address both obstetric violence and obstetric racism at the same time, as people of colour have worse maternal and neonatal outcomes compared to white people.

Dr. Barbora Holubová, Independent national expert on gender equality, Bratislava, Slovakia, presented a case study for Slovakia: evidence, initiative and recommendations.

There have been testimonials of numerous cases of forced and violent sterilisation of Roma women. It was only in November 2021 that a formal apology was made to Roma women and compensation put in place. This was after litigation that reached the European Court of Human Rights, which upheld the claims of Roma women. People undergoing gender transition have been subjected to forced sterilisation and castration. There are high numbers of caesarean sections, episiotomy and tearing (rupture) of the perineum. A legal framework on the issue of obstetric violence is lacking.

Initiatives taken include: a long-term campaign by and pressure from NGOs, the Centre for Reproductive Rights and the Centre for Civil and Human Rights, in relation to forced sterilisation of Roma women; human rights NGOs and visual artists developed documentaries that capture women's stories; and women's NGOs have developed the campaign 'Let's talk about women's human rights by childbirth', have worked to strengthen the communication skills of midwives, have provided training events and workshops, and have stimulated public discussion on the issue.

At an institutional level, the Ministry of Health introduced Standards of Mother and New-born Care, and developed guidance for medical procedures of gender reassignment.

There is a need to: provide healthcare in a way that respects human rights; implement and monitor legal and administrative procedures; systematically collect data on maternity care and regularly publish this data; adopt standards in the fields of obstetrics that reflect scientific developments; provide adequate financial resources for healthcare to ensure a dignified environment; implement training for healthcare workers to increase awareness of these issues and their causes; introduce effective measures to monitor Roma women in maternity care; and create an effective system of independent control and sanctioning in this field.

Stella Villarmea, Professor of Philosophy at the Complutense University of Madrid and Associate Faculty Member in Philosophy at the University of Oxford and Adela Recio Alcaide, Head of Research Studies, Instituto Estudios Fiscales, Madrid, presented a case study for Spain: evidence, initiative and recommendations.

This issue is not about health professionals, it is about systems and practices that need to be updated, and the need for health professional training of an interdisciplinary nature that encompasses matters of technical skills and of gender equality. Perinatal indicators, within official statistics, reveal generalised use of non-evidence-based clinical practices in NHS hospitals. Obstetric interventions rates are well above those recommended by health institutions. Women have been judicially forced to undergo medical interventions. While there has been valuable independent research, there is a lack of official data and there is, further, a need for publication of easily-accessible data by hospitals.

The national legislation does not reference 'obstetric violence', but at a regional level, the 2020 Catalan Law and the 2022 Basque Law include the term. Some manifestations of obstetric violence are addressed under the recent reform of National Organic Law 2/2010, and Law 41/2002 of Patient Autonomy usefully guarantees women's autonomy during childbirth, and emphasises voluntary and informed consent.

Civil society mobilisation on this issue dates from the 1980s but has gained some force through the 2000s. Associations have run campaigns and taken initiatives for birth rights including, Milky Way (Vía Láctea), since 1987, Childbirth is Ours (El Parto es Nuestro), since 2003, and the Observatory of Obstetric Violence, since

2014, among a wide range of associations. The Women's Health Observatory (Ministry of Health) was motivated to coordinate a public debate on the issue with relevant stakeholders, and the result of this was publication of the Strategy for Normal Birth Care in 2007.

This focus on obstetric violence has not been without tensions, and the Spanish Society of Gynaecology and Obstetrics and the General Council of Official Colleges of Physicians resist use of the term 'obstetric violence' and deny the need for policy measures. However, the term 'obstetric violence' valuably addresses the structural and gender dimensions and validates the lived experiences of women.

There is an imperative to listen to the testimonies of women subjected to obstetric violence. While there is evidence and analysis of the occurrence of obstetric violence in Spain, there is a need to collect more data. Spanish health institutions should commit more strongly to the eradication of obstetric violence. There is a need to follow the path already set out with the National Strategy for Normal Birth a good instrument that should be relaunched; and with the use by the state of the 2020, 2022 and 2023 UN CEDAW Recommendations to navigate towards the eradication of obstetric violence.

2.2 Plenary Discussion

The Spanish Strategy for Normal Birth Care was noted as a positive development in a context where movement on this issue can be sensitive, and lack agreement and political support. It was reported that the process for the strategy included a survey of women, and the Ministry listened to the stakeholders. The public debate with relevant stakeholders coordinated by the Women's Health Observatory (Ministry of Health) was a key motivator behind the strategy.

A concern was noted to protect the health professional from litigation in contexts where the woman has been informed of the options and risks, insists on exercising her autonomy, and experiences negative outcomes. Autonomy needs to be respected, it was suggested, as it is in any other area of healthcare. Autonomy does come with responsibility, again as in all other areas of healthcare. The guidelines developed in the Netherlands on care outside the system address this in that, where autonomy is exercised through informed choice, the care professional is responsible for the process but not for the outcome.

A concern was noted that some interventions, deemed to be problematic, such as an episiotomy, were in fact to prevent interventions that would be more intrusive, such as a caesarean section. Addressing obstetric violence is not necessarily to put an end to interventions such as episiotomy, it was suggested, but about ensuring women are better informed and that they give their consent. This is the rationale behind the birth plan procedure in France, which, if applied properly, has real potential to protect both women and health professionals. Informed consent would usefully be in place before the birth process.

The centrality of informed consent was emphasised. Women can seek a caesarean section out of fear of natural birth. Fears need to be mitigated just as risks need to be explained, it was pointed out. In this, clarity of language, and use of mother tongue of the woman was emphasised, in particular with regard to Roma women.

3. OBSTETRIC VIOLENCE: STAKEHOLDER PERSPECTIVES

3.1 Presentations

Basil Tarlatzis, President European Board & College of Obstetrics and Gynaecology (EBCOG) presented.

The term 'obstetric violence' is problematic due to its negative connotations, its suggestion of intent, and its

failure to respect that issues could be due to: an emergency; lack of experience or skills; ignorance; or shortage of health professionals. The term is unjustified and insulting for the vast majority of health professionals. The term 'respectful care' with its positive connotations is suggested.

The procedures identified as forming part of this issue in their over-usage, were developed historically to improve birth outcomes, and reduce complications for babies. There is agreement on informed consent as being mandatory, but there needs to be clarity about handling emergency situations.

EBCOG has published standards of care and are part of FIGO, the international federation which has published a checklist for professionals. Future steps on this issue could usefully include: a precise definition of the issue; surveys to capture precise incidence; evidence-based guidelines; a position statement on the issue; and standards of care.

Gergana Nikolova, European Midwives Association (EMA) presented.

The role of midwife is to be a companion for the woman on a journey to becoming a mother, being with and supporting the woman. The woman and baby are at the centre of the process and healthcare professionals must have the courage to listen.

When it comes to perceptions of violence or indeed of high quality of care, the judge is the woman. There is a responsibility to ensure that the woman is ready to make decisions, is given the information to make these decisions, and is given the chance and the time to make choices.

Midwives need more time with the women. The ante-natal period is key for building trust and enabling responsibility. More time needs to be invested in this period to allow discussion of consent and of choices, and to build trust and responsibility. There needs to be more midwives. There is a need to: be able to work safely; have guidelines; and have enough numbers to follow the guidelines.

Josefine Declaye Tarlatzis, European Specialist Nurses Organisation (ESNO) presented.

Raising awareness, creating safe spaces, and a collaborative approach are key. Raising awareness focuses attention on education and on the imperative to speak out about this issue. Such education includes continuing professional development for healthcare workers. The issue needs to be made visible with monitoring and data collection, and by gathering perspectives from nurses and midwives as well as from the mothers.

Creating safe spaces recognises the physical, social and emotional impact of the experience of obstetric violence. These safe spaces need to be places free of judgement of the woman, which might be based on whatever characteristics. Non-judgemental care requires education too. It needs time to build a birth plan with the mother.

Collaboration involves those responsible for the finances, policy makers, the institutions, the midwives and other professionals, and mothers working together on this issue. Stronger networks need to be developed, data needs to be gathered.

Fabienne Richard, Group for the Abolition of Female Genital Mutilation (GAMS) presented.

GAMS works to bring forward the voice of migrant women in this field, conscious of the language barriers they experience and the stereotyping they are subject to in maternity care. GAMS pursues good practice in providing pre-natal classes for migrant women that includes a visit to the hospital to break down fears. The right to translation and interpretation needs to be fulfilled. Interpretation also requires further time be given to ante-natal processes with migrant women.

Good practice is noted in one hospital where gynaecologists realised they needed to know more of the migrant experience if they were to adequately respond to the needs of migrant women. Training was organised for them in a Red Cross centre, the location being an aid to their understanding of the migrant experience. Such training is also needed in the basic curriculum for healthcare professionals in this field, to enable them to understand and take account of cultural difference.

In its work with healthcare students working in this field, GAMS notes the stress they are under, with, as a result, students deciding not to complete their studies There is a need to introduce training on obstetric violence and on how to react to and address this, especially as a student when you are at the bottom of the hospital hierarchy.

Hélène Sinan and Florence Guiot, Plateforme citoyenne pour une naissance respectée presented.

The Platform provided training for healthcare professionals on respectful maternity care and on obstetric violence in 2023. A range of professionals participated and its success has led to a search to replicate this good practice. The Platform undertook the first survey on obstetric violence in French speaking Belgium in 2021. There was a significant response to this survey and many who participated wanted the space to say more about their experience. Significant levels of obstetric violence were reported, including extreme variations between hospitals in the scale of this.

The survey included a focus on the location of the birth: home, birth centres, and obstetric units. It found the highest rates of obstetric violence in obstetric units and the lowest in home births. The difference across location is analysed in terms of the models of care being different in each, with the obstetric unit focused on the bio-medical/technocratic model of care.

Future steps should include: a concern to hear the voice of the women; establishing an obstetric violence observatory in all EU Member States; offering more choices for women in maternity care provision; full and mandatory transparency on data; and rethinking training of healthcare professionals.

3.2 Plenary Discussion

Terminology was a point of disagreement. It was suggested that opposition to the term 'obstetric violence' is akin to showing you are not willing to engage in the conversation, given that it has been enshrined in legislation since 2006. This blocks necessary bridge building.

On the other hand, it was suggested that the term conflates a broad range of treatments, including the criminal and the unnecessary, but not only these. The term is offensive where intention is not involved. It divides people that need to work together, limiting collaboration. A focus on healthcare ethics is suggested.

It was pointed out, though, that the term obstetric violence addresses non-intentional acts and less so intentional acts, it is a systemic issue. Women need to be at the centre and their perceptions and voice recognised in this. The term obstetric violence, it was suggested, is important from a policy perspective, and it has already taken too long to have obstetric violence recognised as an issue.

Next steps was an area of some significant agreement. Data is important in terms of using the data we have available to us, accompanying the data with stories, and in deploying data as a means of institutional and professional transparency. Ongoing data collection continues to be important. The value of having an observatory on obstetric violence in each Member State was reiterated.

The need for training healthcare professionals, developing guidelines for healthcare professionals, and establishing standards for healthcare provision were emphasised, capturing the systemic nature of this issue. Training, at all levels, needs to address aspects beyond medicine, to embed a focus on ethical principles and gender equality.

The emotional safety of women needs consideration in future action, their voice needs to be heard. Informed consent and choice, and the time required for this need to be central. Within this, attention needs to be given to intersectionality and the specific needs of different groups of women. Additional resources for the sector, including more midwives, are important.

There is a need noted to find the common ground across stakeholders on this issue, establish shared understanding and definitions, and create the conditions for all involved to find solutions and work together towards its elimination.