

Focus

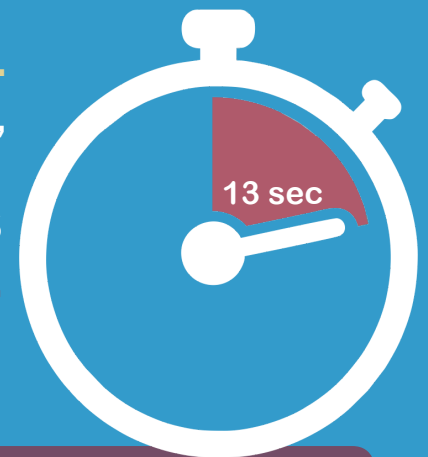
# CHILDBIRTH

From human rights abuses to autonomous decision-making

**B**irth is a very special, intimate and defining moment in the lives of the parents and child, an integral part of a transformation that is both physical and psychological. According to the United Nations, approximately 78 million children are born worldwide each year. That means there are almost the same number of individuals giving birth, and

in many cases there are other parents and siblings whose lives are fundamentally altered by the birth of a new child. What must happen to ensure that childbirth is safe, dignified and self-determined? How can we ensure a respectful birth culture?

**IN 2019, ONE NEWBORN BABY DIED EVERY 13 SECONDS. THAT REPRESENTS 2.4 MILLION INFANTS A YEAR, AND 47% OF ALL CHILD MORTALITY CASES AROUND THE WORLD. MATERNAL AND INFANT MORTALITY IS DEMONSTRABLY REDUCED IF PROFESSIONAL ASSISTANCE IS PROVIDED BEFORE, DURING AND AFTER CHILDBIRTH.**



## THE RIGHT TO FREE CHOICE OF WHERE TO GIVE BIRTH AND WITH WHOM

It is important that the individual giving birth has the free choice of where to give birth and to decide who should attend the birth, whether it be for medical assistance or emotional support.

But does “free choice” have any meaning when:

- the next available maternity clinic is difficult to reach?
- no midwives or other skilled attendants can be present at the birth?
- there is real, justifiable concern that the birthing person\* and baby may not survive?

And why do some people decide to give birth alone despite having access to professional assistance?

## RESPECT FOR HUMAN RIGHTS THROUGHOUT PREGNANCY, BIRTH AND THE POSTPARTUM PERIOD

The protection of human rights in childbirth applies to the individual giving birth, the baby, other parents or caregivers, siblings, and health professionals such as midwives and obstetricians. Most important of all is the right to physical and psychological integrity and the right to be treated in an entirely respectful and non-coercive way.

These human rights are not respected when:

- the individual giving birth experiences discrimination or violence at the hands of midwives or doctors;
- medical interventions are carried out without the birthing person being provided with the appropriate information or giving their consent; and/or
- childbirth is a predominantly traumatic experience.

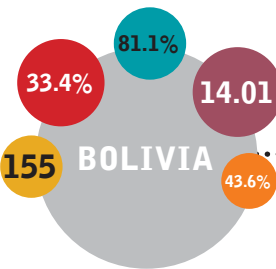
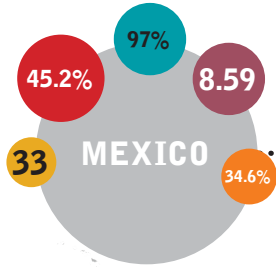
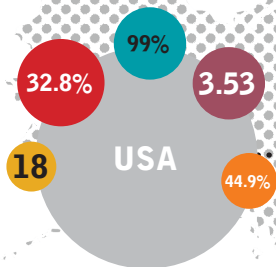
**MATERNAL MORTALITY HAS DECLINED BY AROUND 38% WORLDWIDE SINCE 2000, AND INFANT MORTALITY BY AS MUCH AS 50% SINCE 1990.**



\* We use “birthing person” to recognize that not all people who become pregnant and give birth identify as a woman or a mother.

# STRUCTURAL VIOLENCE IN

- Deaths of birthing persons per 100,000 live births up to 28 days after birth
- Caesarean Section Rate
- Percentage of births which are professionally assisted
- Infant deaths per 1000 live births up to 28 days after birth
- Premature Birth

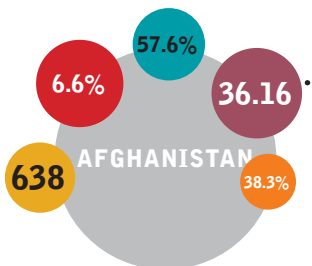
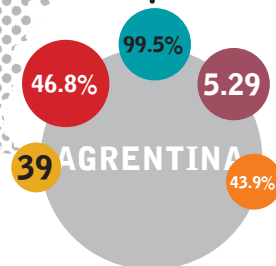
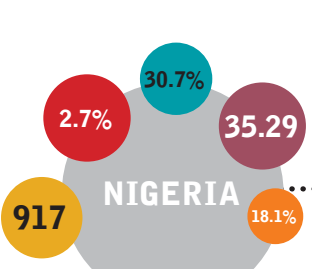
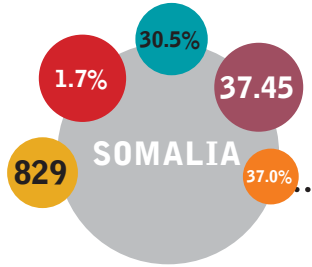
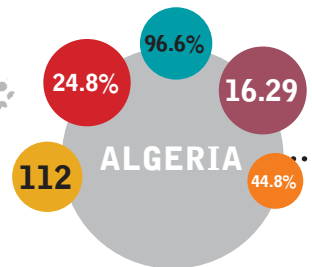
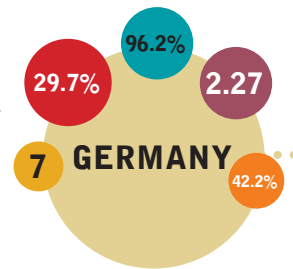


Statistically, **38** out of every 1,000 children born worldwide will die before they reach their fifth birthday. But this is the global average, which is very unequally distributed: in

Sub-Saharan Africa **76** children out of every 1,000 die, in Southern Asia **39**, and in Central Europe just **two to seven**.

A child's chances of living past its fifth birthday depend primarily on where

it was born. **80%** of all child mortality cases occur in Sub-Saharan Africa and Southern Asia.



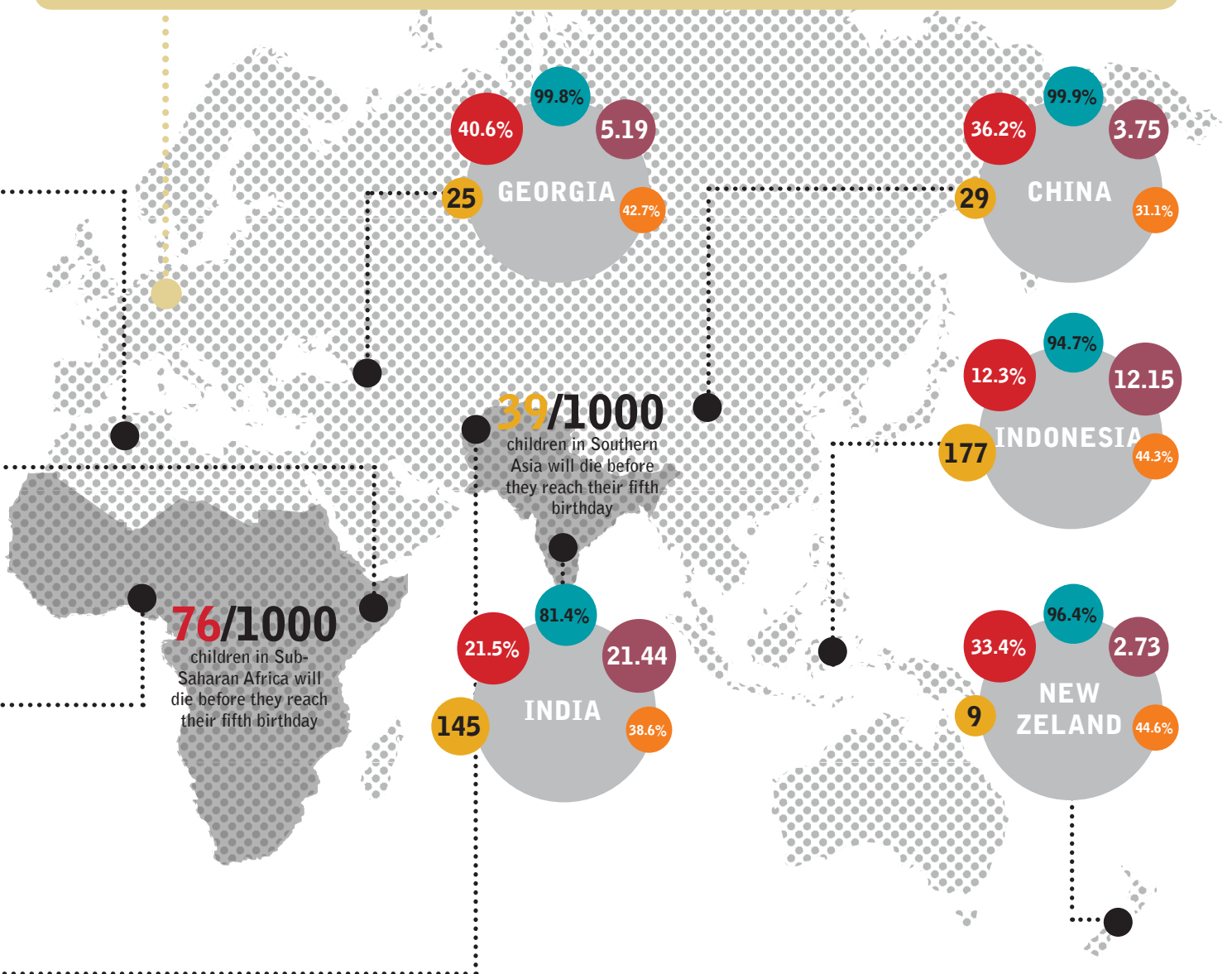
Sources:

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# CHILDBIRTH

## THE SITUATION IN GERMANY

In Germany, the right to choose where to give birth has been enshrined in law since 2012 (Section 24, SGB V). During pregnancy, individuals can choose whether they wish to use the services of a midwife, a male doctor or a female doctor. They can also choose at which stage of the pregnancy to get in contact with the midwife and/or doctor and can get advice from either one on where to give birth. They can then consider the issue at their leisure and plan for the birth in accordance with their own wishes – at home, in a birthing centre, or in hospital as either an inpatient or outpatient, in a midwife-led delivery room with an individually chosen midwife on an one-to-one basis, or in a perinatal centre with adjoining paediatric clinic. In practice, however, this “free choice” is restricted by the limited options for giving birth outside of hospital (e.g. shortage of midwives, higher insurance rates) and by the narrow scope of health insurance providers’ risk catalogues. In any case, it is important that clinics are within easy reach. In some rural areas of Germany adequate care cannot be guaranteed. The North Sea island of Sylt, for instance, has had no maternity ward since 2014. Pregnant individuals must move to the mainland long before their expected delivery date and simply wait out the rest of their pregnancy there.



SOME **94%** OF ALL MATERNAL DEATHS OCCUR IN LOW AND LOWER MIDDLE-INCOME COUNTRIES. **SUB-SAHARAN AFRICA** AND **SOUTHERN ASIA** ACCOUNTED FOR APPROXIMATELY **86%** OF THE DEATHS IN 2017.

# THE DIMENSIONS OF OBST



# OBSTETRIC VIOLENCE

## INSTITUTIONAL VIOLENCE

Obstetric wards in hospitals are often characterised by economising, clear hierarchies, staff shortages and rigid routines. All this can give rise to a culture that does not adequately respect the rights of the individuals giving birth. Internal standards and legal guidelines can put midwives and doctors in situations where they are no longer able to adequately respect the autonomy of a person who is giving birth. For example, the right “not to know” something (e.g. abnormalities observed during examinations) is often not respected, as there is a general consensus that the duty to inform takes priority. Increased streamlining in hospitals also plays a role in the rising incidence of caesarean sections. In 2015, WHO confirmed that the increased caesarean section rate of 10 to 15 percent had no bearing on the number of maternal and infant deaths. However, the rate of caesarean sections does seem to go down when obstetric teams receive appropriate special training.

### RACISM SEEN AS A CAUSE OF HIGHER MATERNAL AND INFANT MORTALITY RATES IN THE USA

From 2011 to 2013, the pregnancy mortality rate of Black individuals in the United States was three to four times higher than that of white individuals, regardless of socioeconomic status. The infant mortality rate of Black babies is also twice that of white babies. Alongside genetic causes, premature birth, low birthweight, accidents, and sudden infant death syndrome, researchers have now identified racism as a cause of infant mortality. The fact that Black women are more affected by general risk factors does not sufficiently explain the higher degree of morbidity and mortality in childbirth. Thus “race” is an independent risk factor for birthing people and their babies in the United States. Experiences of racism on a structural and personal level probably have a direct impact on the health of Black individuals and their newborn babies. It also seems that obstetrician-gynecologists and delivery room staff do not treat Black and white patients the same. Currently, however, there is a lack of sufficient reliable data to make any concrete statements about this issue.

## STATE VIOLENCE IN THE CONTEXT OF CHILDBIRTH

States around the world regulate pregnancy, childbirth and life with the newborn in various ways, often encroaching on personal freedoms. Some countries do not provide adequate healthcare and health insurance, and/or they do not ensure that midwives and doctors are sufficiently trained. Also, some states have legislation that limits choice of where to give birth. Home births are officially banned or obstructed through legal obstacles in, for example, the Czech Republic, Hungary, Australia, China and many US states.

In many countries it is difficult to obtain a birth certificate for a child whose parents do not fit in with the prevailing legal or societal norms. The bureaucratic hurdles are immense for parents who have a different nationality or no documentation, for parents who are unmarried, disabled, trans or intersex, or for those who wish to have more than two parents responsible for the child. In some cases, parents in these circumstances are confronted with direct expressions of structural violence. For example, depending on the context they may face deportation, exclusion from the social security system, withdrawal of child custody, or the removal of the child into state care. Fear of such penalties can lead pregnant individuals to opt to give birth outside of the system, despite the risks.

### DEADNAMING ON GERMAN BIRTH CERTIFICATES

In Germany it is not possible for trans men to have their names entered on the birth certificates of the children they give birth to. Instead, their “dead name” (the name of a trans person before transitioning) is entered, along with the wrong sex, as the state has decided that the person who gives birth to a child is automatically its mother. This gives rise to an absurd situation where a child’s birth certificate names as one of its parents a person who no longer exists. In many cases, such families must seek a court order to prove parenthood, for instance when they wish to travel abroad.

# VIOLENCE IN THE DELIVERY ROOM

## – FROM DISRESPECT TO EXISTENTIAL TRAUMA

### PHYSICAL VIOLENCE



FACE SLAPPING



PINCHING



SHOVING



PINNING DOWN



FUNDAL PRESSURE,  
EPISIOTOMY,  
ADMINISTRATION OF  
DRUGS (E.G. OXYTOCIN)  
WITHOUT INFORMED  
CONSENT

E.G. VAGINAL  
EXAMINATIONS OR  
MANIPULATION OF  
THE CERVIX WITHOUT  
INFORMED CONSENT

### SEXUALISED VIOLENCE

### VERBAL VIOLENCE

THREATS AND  
SHOUTING



SHAMING AND  
DISPARAGEMENT  
RELATING TO SUCH  
THINGS AS PAIN  
TOLERANCE LEVELS  
AND LOSS OF  
ENERGY (“YOU’LL  
NEVER MAKE IT  
THROUGH THAT  
WAY!”)



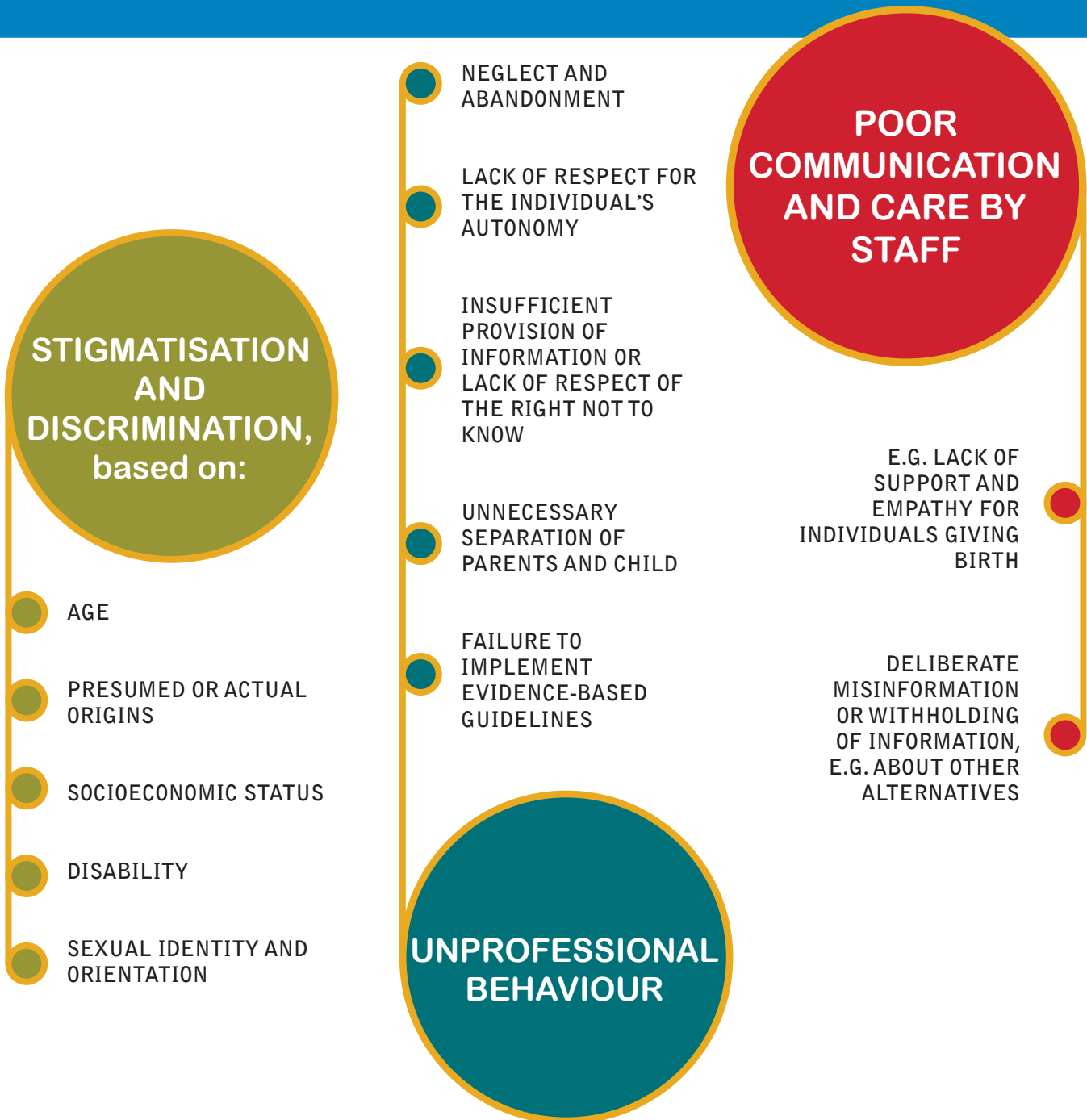
MOCKING



THE MOST COMMON CAUSES OF **MATERNAL DEATH** ARE **SEVERE BLEEDING, INFECTIONS, PRE-ECLAMPSIA**, COMPLICATIONS DURING DELIVERY, AND **UNSAFE ABORTION**. VERY YOUNG BIRTHING PERSONS **AGED 10 TO 14 ARE AT THE GREATEST RISK**.

Empirical studies into traumatic experiences of childbirth show somewhere between 9 and 45 percent of all individuals giving birth are affected. The main complaints are lack of care, disrespectfulness, and violence during the birth. The term “violence in the delivery room” refers to both intended and unintended actions.

Traumatic experiences of childbirth are associated with a higher risk of perinatal psychological disorders such as postpartum depression and post-traumatic stress disorder. This has a direct impact on the quality of life of the affected parents and their child as it can lead to disruptions in the parent-child relationship and thus impair the child’s development. In addition, it can disturb the harmonious coexistence of the family and impact on the parents’ relationship as a couple.



THE **MAIN FACTORS** PREVENTING ACCESS TO ADEQUATE OBSTETRIC CARE INCLUDE **LONG DISTANCES TO MATERNITY CLINICS, POVERTY, LACK OF INFORMATION, INADEQUATE OR UNPROFESSIONAL HEALTHCARE SERVICES, AND CERTAIN CULTURAL BELIEFS AND PRACTICES.**

# INTERNATIONAL CONVENTIONS AND REPORTS ON VIOLENCE AGAINST WOMEN

Violence during pregnancy, childbirth and the postpartum period is an issue that has a direct impact on different individuals in specific situations, usually involving several intersectional dimensions at once. There are dynamics running through every level that conceal, normalise and therefore legitimise forms of violence and the way they are perceived in society.



## WHO STATEMENT

In 2014, WHO issued a statement on the “prevention and elimination of disrespect and abuse during facility-based childbirth”. It called for five actions to be taken: 1) supporting more research and action on disrespect and abuse; 2) initiating programmes to improve the quality of maternal health care; 3) emphasising the rights of women to dignified, respectful healthcare; 4) generating data related to respectful and disrespectful care practices; and 5) involving all stakeholders, including women, in efforts to improve quality of care.



## REPORT OF THE UN SPECIAL RAPPOREUR ON VIOLENCE AGAINST WOMEN

In July 2019, Dr Dubravka Šimonović, the UN Special Rapporteur on violence against women, prepared a report on obstetric violence based on over 130 submissions from around the world as well as regional reports. The report makes clear that systematic violations of women’s human rights occur worldwide in births taking place in and outside of healthcare facilities.



## ISTANBUL CONVENTION OF THE COUNCIL OF EUROPE

The so-called Istanbul Convention is an international treaty concluded under the auspices of the Council of Europe (CoE) in 2011. To date, it has been signed and ratified by 35 of the 46 CoE member states. It states in Article 1a that the “purposes of this Convention are to protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence”. Following on from this, in 2019 the Parliamentary Assembly of the CoE adopted Resolution 2306 on obstetric and gynaecological violence, which states in Article 3 that: “Obstetrical and gynaecological violence is a form of violence that has long been hidden and is still too often ignored.” Overall, member states are urged to conduct information and awareness-raising campaigns on gynaecological and obstetrical violence and to take concrete steps to put an end to such violence.

## THE CONCEPT OF SELF-DETERMINED BIRTH

From the mid-20th century, obstetric practices in hospitals in high-income countries were characterised by mechanisation, medicalisation and the idea of “programmed childbirth” using labour induction and other medical interventions. During the 1970s and 80s, the women’s movement in the global West took a critical stance towards such practices. In opposition to “programmed childbirth” arose the concept of “natural childbirth”, which aimed to do away with painkillers and medical interventions to the greatest degree possible. At the same time, the concept of “self-determined birth” developed. In 1971, feminist non-profit organisation Boston Women’s Health Book Collective published “Our Bodies, Ourselves”, which contained important information about the fertile female body, sexuality, pregnancy and childbirth. More than four million copies were sold. The book thus made a significant contribution to sexual health education, but it also allowed women to gain control of important issues directly affecting them; no longer would women’s health be defined by an elite group of white, upper middle-class men.

Within our capitalist society, directed as it is towards economic efficiency even in the realm of obstetrics, self-determined birth is not easily achievable. It requires the birthing individual to be enabled to give informed consent – which is not easy in the high-pressure atmosphere of the delivery room, often characterised by fear, helplessness and exhaustion. In this context, parents are often made to feel responsible for their own traumatic childbirth experiences – a typical example of victim blaming. And so we must aim to open up scope within the capitalist system for women and other birthing people to give genuine consent.

## “BIRTHING JUSTICE” AS PART OF REPRODUCTIVE JUSTICE

During debates on healthcare reform in the United States in 1994, a group of Black feminists first articulated the concept of “reproductive justice” in opposition to the reductionist tendency of the feminist movement to focus entirely on the right to abortion. This opened up the discourse to include an intersectional perspective on motherhood and parenthood, and made the experiences of primarily Black and Indigenous women more visible – for instance, lack of access to healthcare, and parenthood against the backdrop of anti-natalist programmes and systemic denigration such as taking children into care. The right to have a child and to parent that child in a safe and healthy environment thus became part of the feminist agenda alongside the right not to have a child.

In 2010, the National Advocates for Pregnant Women (NAPW) called upon other organisations working in the area of reproductive justice to give birth attendance and obstetric care a more prominent place on their agendas. The NAPW pointed out that topics such as free choice of where to give birth, the shortage of midwives, and the excessive rate of caesarean sections were not receiving enough attention, reducing the activist potential of important concerns such as the self-determined decision to have a child and to give birth in the preferred way.

IN 2017, ROUGHLY **810 PEOPLE**  
**WORLDWIDE DIED**

EACH DAY FROM **CAUSES**  
**RELATED TO**

**PREGNANCY**

**AND CHILDBIRTH OR**

**WITHIN 42 DAYS**

**SUBSEQUENTLY. IN**

**ABSOLUTE NUMBERS**

**THAT IS 295,000**

**PEOPLE.**



# NEW BIRTHING APPROACHES



## HUMAN RIGHTS IN CHILDBIRTH (HRIC)

HRIC is an international NGO that grew out of its first conference, which was held in The Hague, the Netherlands in 2012. One of the first major events on the topic, the conference brought together over 300 stakeholders from all over the world, including midwives, doctors, legal experts, ethicists and healthcare users. Further interdisciplinary conferences followed in locations such as the United States, South Africa, Eastern Europe and India.

[www.humanrightsinchildbirth.org](http://www.humanrightsinchildbirth.org)



## BLACK MAMAS MATTER ALLIANCE (BMMA)

BMMA is a Black women-led cross-sectoral alliance with headquarters in Atlanta, Georgia, USA. Its main aims are to change policy, cultivate research, forge networks and bring about a culture shift in obstetric care for Black women and birthing people and their babies. The alliance's work is grounded in birth justice, reproductive justice and human rights.

[www.blackmamasmatter.org](http://www.blackmamasmatter.org)



## ROSES REVOLUTION DAY

This global day of action against obstetric violence was launched in 2011, inspired by an idea of birth activist Jesusa Ricoy. Since then, it has been celebrated annually on 25 November and aims to make violence during childbirth visible to the public. Women place pink roses, often accompanied by a personal letter, in front of the delivery rooms where they have experienced violence. The organisers of #rosesrev in Germany include the Initiative for Fair Obstetrics in Germany and Traum(a) Geburt e.V.

[www.rosesrevolutiondeutschland.de](http://www.rosesrevolutiondeutschland.de)

[www.gerechte-geburt.de](http://www.gerechte-geburt.de)

[www.traumageburtev.de](http://www.traumageburtev.de)



## BLACK WOMEN BIRTHING JUSTICE (BWBJ)

BWBJ is a grassroots collective in Oakland, California, USA, that provides guidance to Black women and individuals in the African Diaspora throughout the childbirth process, with the goal of ensuring that every pregnant person has an empowering birth and postpartum experience. Other aims include raising awareness, influencing healthcare policy and keeping birth sacred.

[www.blackwomenbirthingjustice.com](http://www.blackwomenbirthingjustice.com)

# BY INTERNATIONAL NGOs



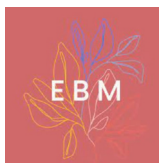
## MOTHER HOOD E.V.

This German charity organisation is an influential parents' initiative that campaigns for better and fairer obstetric care. As a patient advocacy group, it represents the interests of birthing people and their families before the Federal Joint Committee overseeing health insurance funds, as well as in matters such as medical guidelines development and legislative proposals. In 2019, Mother Hood e.V. submitted a country report on Germany to the UN Special Rapporteur on violence against women, Dr Dubravka Šimonović.  
[www.mother-hood.de](http://www.mother-hood.de)



## CRITICAL MIDWIFERY STUDIES COLLECTIVE

Members of the Critical Midwifery Studies Collective are organizing the 2022 summer school of Utrecht's University of Humanistic Studies. The international summer school, which is being held virtually from 11–15 July 2022 under the title of "Humanizing Birth", will be co-hosted by the Chilean Observatory for Obstetric Violence, the University of Cape Town, the Department of Midwifery Science of Amsterdam's VU University Medical Center, City University London, and the Department of Humanities and Social Sciences of IIT Bombay.  
[www.criticalmidwiferystudies.com](http://www.criticalmidwiferystudies.com)



## DOULAS AND MIDWIVES

There are of course midwives, doctors and, above all, doulas who provide trauma and discrimination-sensitive care during pregnancy, birth and the postpartum period. The use of doulas to accompany women and birthing people has come about in different ways in different places. In the United States, in particular, doulas have become fairly well established as a result of activism calling for better childbirth support for Black and Indigenous mothers as well as queers. In Germany, the Düsseldorf-based organisation Empowered Birth Movement aims to improve access to health information and peer support so that people can "make informed decisions for themselves and their families". Doulas are a central part of achieving this goal. However, it is often very expensive for families to hire a doula.

In addition, there are an increasing number of feminist midwife collectives that focus on the self-determination of those they accompany. One example is the midwife collective Cocoon in Berlin, whose approach is explicitly queer-feminist and sensitive to discrimination.  
[www.empoweredbirthmovement.com](http://www.empoweredbirthmovement.com)  
[www.cocoon-hebammenkollektiv.de](http://www.cocoon-hebammenkollektiv.de)

## LAWS AGAINST OBSTETRIC VIOLENCE

In 2008 Argentina became the first country in the world to pass a law against obstetric violence, also known as abuse in childbirth. Since then, Venezuela, Panama, Bolivia and the Mexican state of Veracruz have followed Argentina's example. Obstetric violence is a topic linked to gender-based violence and mistreatment, and to structural violence within the healthcare system.

# FROM HUMAN RIGHTS ABUSES TO AUTONOMOUS DECISION-MAKING

**M**ore and more grassroots organisations are calling for changes to obstetric practice, with a greater focus on gender-equitable healthcare. Preventing maternal and infant deaths cannot be the only goal; we must also work to make childbirth an affirming and dignified experience. Respectful and equitable obstetric practice requires:

- the establishment of state-financed care structures;
- straightforward access to those structures, including any necessary medications and surgical procedures;
- high-quality comprehensive training of midwives and obstetric personnel;
- sufficient staff numbers to ensure one-to-one birth attendance in hospital settings;
- dismantling of hierarchies; and
- protecting the right to choose where to give birth and who should attend the birth.

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