Women's rights in the process of labour and childbirth

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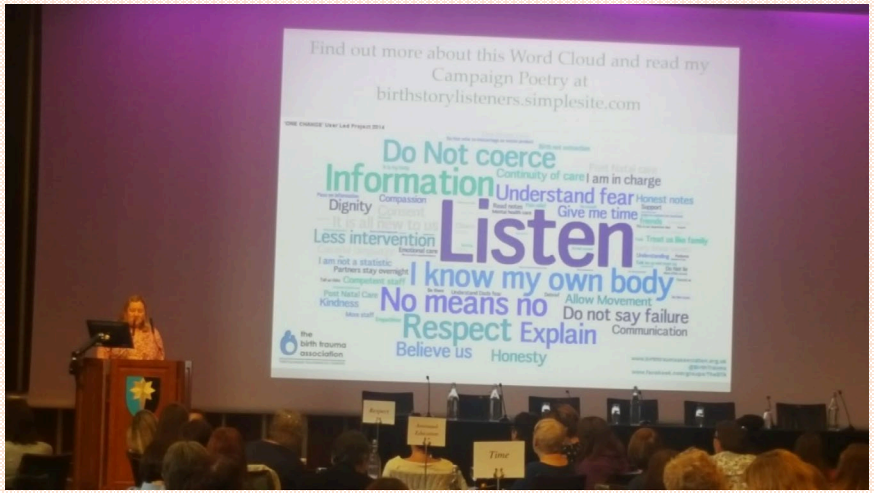
Women's rights are human rights. The last century has seen a long struggle, around the world, for legal recognition of that basic fact



A lot of Social movements struggle to change childbirth practices

Was founded in the Hague in 2012 with the vision to protect and fulfil the full spectrum of women's rights in pregnancy and childbirth.

To be born at home – is a human right Lithuania

CAESAREAN BIRTH - YOUR BABY, YOUR BODY, YOUR LIFE, YOUR CHOICE

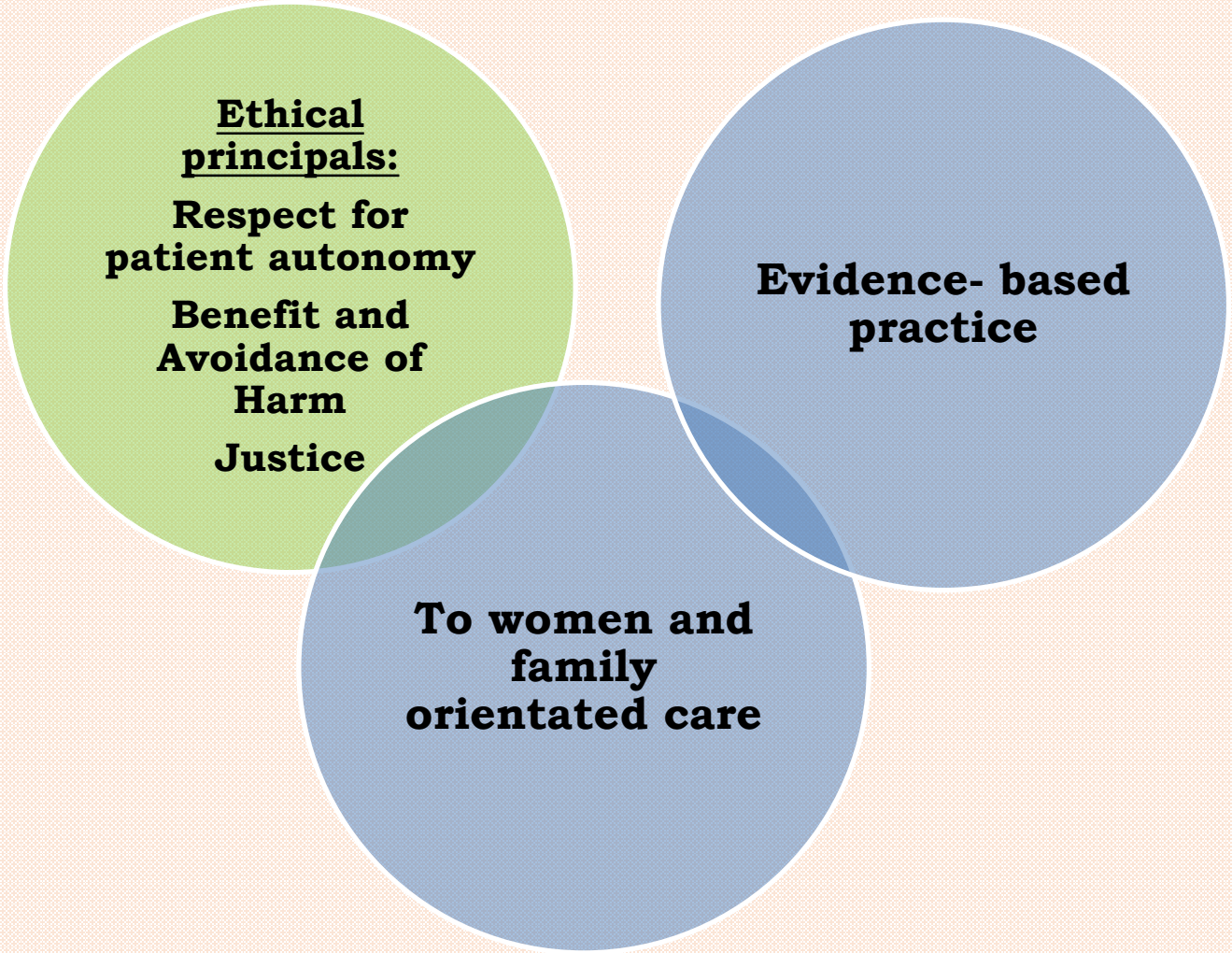
An organisation dedicated to redressing the balance in caesarean research, communication and maternity care

The birth of a child is one of the most intense and significant moments of human existence

Birthing women's rights:

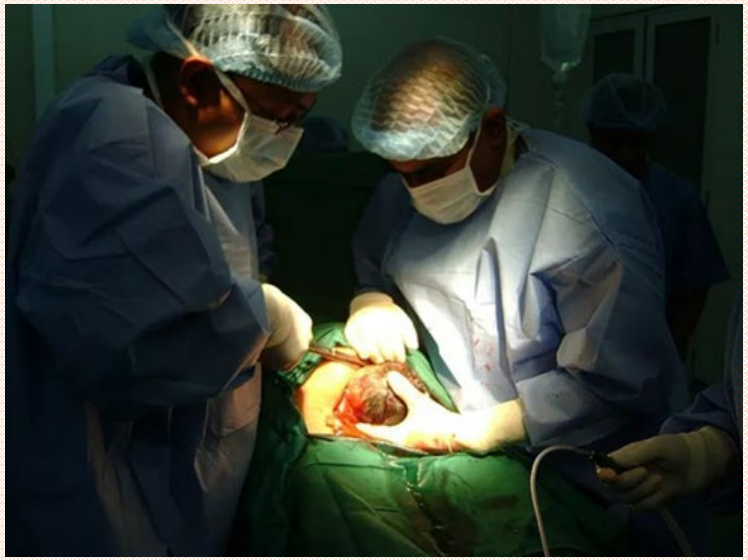
- Autonomy
- Privacy and confidentiality
- Freedom from discrimination
- Safe and appropriate maternity care that respects her dignity
- Make choices about her own pregnancy and childbirth
- To choose the circumstances in which they give birth
- The right to information and informed decision making

Ethical and legal duties of professionals



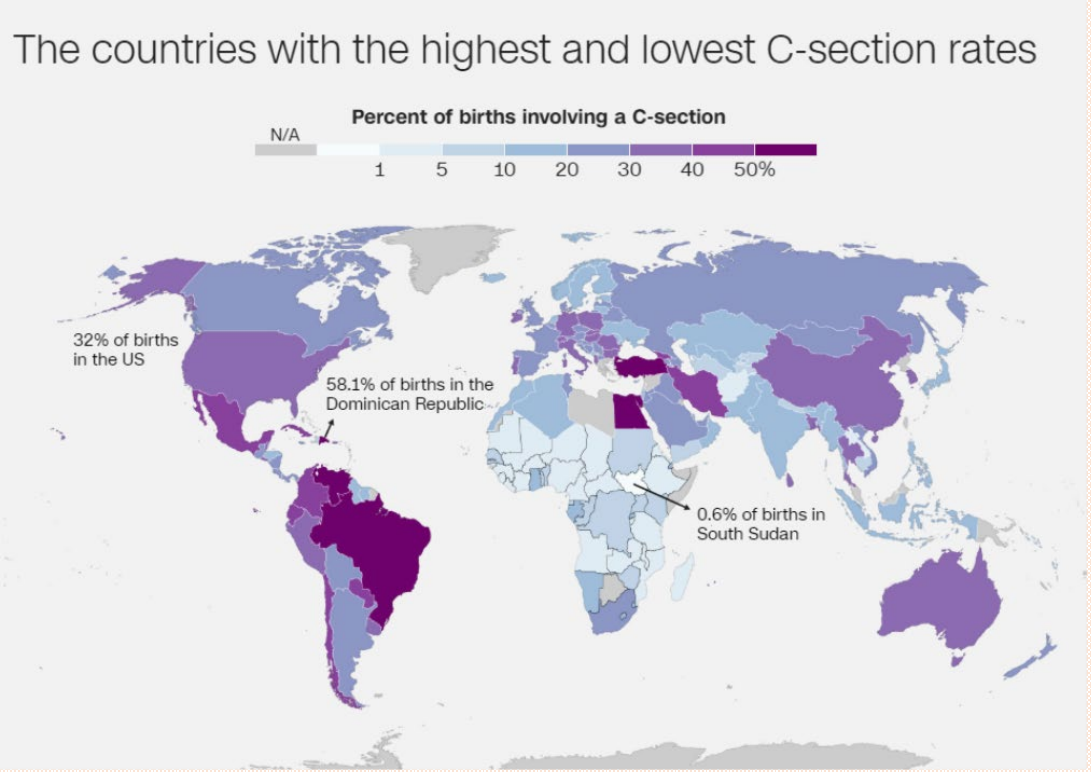
Birthing women's rights for discussions

To choose the mode of childbirth – C-section on maternal request



To choose the place of childbirth – planned birth at home due to fear of obstetrics violence

C-section rates



Region	2000	2015
Global	12.1%	21.1%
West and Central Africa	3%	4.1%
Eastern and Southern Africa	4.6%	6.2%
Middle East and North Africa	19%	29.6%
South Asia	7.2%	18.1%
East Asia and Pacific	13.4%	28.8%
Latin America and Caribbean	32.3%	44.3%
Eastern Europe and Central Asia	11.9%	27.3%
North America	24.3%	32%
Western Europe	19.6%	26.9%

Rates of births by C-section in 2015, stratified by region

Source: The Lancet, "Global epidemiology of use of and disparities in caesarean sections", October 2018
Graphic: Will Houp, CNN

Ties Boerma, Carine Ronsmans, Dessalegn Y Melesse, Aluisio J D Barros, Fernando C Barros, Liang Juan, Ann-Beth Moller, Lale Say, Ahmad Reza Hosseinpoor, Mu Yi, Dácio de Lyra Rabello Neto, Marleen Temmerman. Lancet 2018; 392: 1341–48.

Maternal Request Is not to blame for an Increase in the Rate of Cesarean section (the study in Lithuanian)

- **Results**. Overall, 82.4% of the participants in 2006 and 74.5% in 2011 thought that women should be able to choose the mode of delivery in a low-risk pregnancy

- If they had had such an opportunity, 15.2% of women in 2006 and 14.9% in 2011 would have chosen cesarean section without any medical indication

- **Conclusions**. Approximately 15% of Lithuanian women would request an elective cesarean section, and this percentage did not change during the 5-year period. While the national cesarean section rate is increasing with every year, it seems that "maternal request" cannot be blamed for this phenomenon
- 25-26% rate in Lithuania
- The gold standard of CS –10-15% WHO

Preventive ethics approach, designed to prevent ethical conflicts in clinical practice

World Health Organization	Caesarean sections should ideally only **be undertaken when medically necessary.** Implementation of evidence-based clinical practice guidelines combined with structured, mandatory second opinion for caesarean section indication is recommended and senior clinicians able **to provide mandatory second opinion for caesarean section indication.**
FIGO International Federation of Gynecology and Obstetrics the Global Voice for Women's Health	Any time a cesarean section **is medically indicated**. The principle of autonomy provides that an individual is able to decide what is best for her-self. The physician then has **a moral obligation to refer the patient to another obstetrician** known usually to comply with such a request.
ACOG The American College of Obstetricians and Gynecologists WOMEN'S HEALTH CARE PHYSICIANS	After exploring the reasons behind the patient's request and discussing the risks and benefits, if a patient decides to pursue cesarean delivery on maternal request, the **following is recommended:** cesarean delivery on maternal request should **not be performed before a gestational age of 39 weeks;** patients should be informed that the risks of placenta previa, placenta accreta spectrum, and gravid hysterectomy increase with each subsequent cesarean delivery.
NICE National Institute for Health and Care Excellence	If after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, a **planned caesarean section should be offered**. An obstetrician unwilling to perform a caesarean section should refer the woman to an obstetrician who will carry out the procedure.

Women: Caesarean section should be available on request

- *Facebook*: Caesarean Birth: “Help! I’ve requested a caesarean birth but have been told no – what can I do now? I am feeling distressed and anxious, and frustrated that my informed choice is being denied”.

- The mother's autonomy should be paramount
- Any denial of choice, providing the woman the capacity to make a reasonable decision, is passively paternalistic and unethical

CASE STUDY in Lithuania

- Pregnant woman 32 years old, II childbirth, fetus breech presentation, she was preparing for the planned cesarean section (she refused the correction of fetus position)
- *Informed consent process*
- Caesarean section was performed, the healthy boy's weight 3360g

Is it was a right decision?

- **AUTONOMY**. It can be argued that declining to perform cesarean delivery on mother request is against the principle of autonomy, however, in respecting autonomy, there is a risk of devaluing expert clinical judgement
- **JUSTICE**. In a state-funded healthcare system, there is an ethical duty to society *to allocate healthcare resources wisely* to procedures and treatment for which there is clear evidence of a net benefit to health
- On the other hand, *the fiduciary duty to a woman is to favour her interest* over the interest of others
- **BENEFICENCE and NON-MALEFICENCE**. When taking a course of action, the health professional should be convinced that it has the greatest chance of *benefit with the least risk of harm.* In the absence of clear evidence it is difficult to conform to these principles of beneficence and non-maleficence

Planned home birth- preparing for the birth of child is a personal journey, not a standard path

- In 2010, the European Court of Human Rights recognized that the right to privacy, the foundation of reproductive rights in Europe and the United States, applies to childbirth. In the case of ***Ternovszky v. Hungary***, the Court held that, as a woman has the right to choose whether to give birth to a child, she also has the right to choose the circumstances in which she gives birth
- The Court held that the state violates this human right if it fails **to legitimize the choice for home birth** through regulation, and if it sanctions birth professionals, in particular midwives, for supporting women in that choice by attending them at home
- **That holding was revolutionary** because it opened up a consideration of the state's obligations around childbirth and medical monopoly

Statistics of planned home births

Country	Rate
Netherlands	13%
Western countries	0,5-2,2%
Denmark	1-2%
Lithuania	0,3-0,4%
Iceland	2,2%
Sweden	O,7/1000
Norway	0,5/1000
France	1%

Why women choose the home birth?

- Out-of-hospital practices are care practices of **support and comfort,** positively affect the exercise of women`s autonomy
- The care practices that negatively interfere with women`s autonomy are **standardised or routine practices**, practices that intensify the painful sensation of childbirth, and cold and impersonal healthcare practices

Obstetric violence in the daily routine of care and its characteristics. Danúbia Mariane, Barbosa Jardim, Celina Maria Modena. Rev. Latino-Am. Enfermagem 2018;

Typology	Examples
Verbal violence	Rude, disrespectful, vexatious, coercive, discriminatory, moralistic, critical, ironic and **negative comments** that expose women to embarrassment, inferiority, and humiliation. The presence of **jargons such a**s "*Why are you crying? you did not cry when you were doing it!*"; ***"Oh, don't cry, come on, next year you're here again";*** *"If you do not force, your baby will suffer"; "Shut up and push the baby"; "If you scream, I stop now what I'm doing".*
Physical violence	**Repetitive and aggressive digital vaginal examination**; routine use of episiotomy; unnecessary cesarean section; lack of adequate pain management (before, during and after delivery); realization of procedures **without adequate analgesia** (curettage, manual removal of placenta, **suturing**, cesarean delivery); use of directed pulls; slaps and pinches on the legs; physical restraint of legs and arms during normal or cesarean delivery; Kristeller's maneuver.
Psychological violence	**Threats; shouts**; authoritarian and hostile speech; intimidation before patient behavior; blackmails made by the staff; blaming women in situations such as: fetal distress (or non-reassuring fetal state); difficulty in performing pulls during the expulsive period. Attributing the characteristic of incapacity to give birth to women.

Sexual violence	Realization of digital vaginal examination without gloves; manipulation of genitals brutishly and disrespectfully, touching the body and rectal examination on the woman without her consent.
Social discrimination	Disrespect, stigma, prejudice or differential treatment to women because of their color, race/ethnicity, or social, economic, marital, sexual choice, religion, and schooling. Financial abuse by professionals.
Neglect of care	Negligent care, abandonment, refusal to promote care for women considered “complaining”, “scandalous”, “unbalanced”, “noncooperative” “questioning”. To procrastinate assistance to women in situations of abortion
Inappropriate use of procedures and technologies	**Iatrogenic procedures; abusive use of oxytocin; immobilization in the bed during labor; delivery in lithotomy position; routine amniotomy; continuous routine fetal monitoring; prolonged fasting without indication; inadequate management of pain without justification; no skin to skin contact and early clamping of umbilical cord.**

Giving birth can be a gentle, joyful and even enjoyable process—be it at home, birthing centre or hospital, as long as the woman feels supported and respected with her choices

- **In Lithuania**: There is a clear gap between medicine, the law and birthing women's rights
- The law and obstetric practice with its guidelines, protocols and recommendations are out of synchronization
- As long as this gap continues, the pregnant and birthing women's rights will be vulnerable to continued violation