



JOINT RESPONSE TO OHCHR CALL FOR SUBMISSIONS: Mistreatment and Violence Against Women During Reproductive Health Care with a Focus on Childbirth

The [Royal College of Midwives](#), [Birthrights](#), [White Ribbon Alliance UK](#) (WRA UK), and [Make Birth Better](#) are organisations working to promote all women's rights to quality maternal and reproductive care.

Together we welcome the opportunity to provide evidence on the UK context to Special Rapporteur, Ms. Dubravka Šimonović for her thematic report on mistreatment and violence against women during reproductive health care and childbirth.

UK Policy and Context

Better Births Report

In 2016 the report of an independent [review of national maternity services](#) commissioned by NHS England delivered a bold vision for the future of English maternity care:

'Every woman, every pregnancy, every baby and every family is different. Therefore, quality services (by which we mean safe, clinically effective and providing a good experience) must be personalised. Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.'

In relation to out-of-hospital birth the report recommended that women:

- should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising those choices through their own NHS Personal Maternity Care Budget.
- should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option.

The recommendations echoed a series of research and policy documents actively promoting out-of-hospital birth for 'low-risk' women.

We are now three years into the five year Maternity Transformation Programme to implement the findings of "Better Births". One of the main pillars of this programme has been continuity of carer for pregnant women with Trusts tasked with demonstrating that 20% of the women under their care were receiving continuity of care by March 2019, with a target of 35% by March 2020 and "most" women by

2021. Women receiving care from the same midwife or small team of midwives experience better outcomes and also increased satisfaction with their care. On one hand there is a strong desire from many to see this ambition achieved whilst there is also acknowledgement of the challenges involved, in bringing along a workforce that is not used to this model of care, and with increasingly constrained resources.

NHS England Review

In 2017 the Quality Working Group of the Maternity Review was asked to assess existing service quality in England, and how it varies. The following report, the [National Review of Maternity Services: Assessment of Quality in Maternity Services](#) identifies several key data points of concern:

- 26% of women did not always feel involved in decisions made about their care during labour and birth.¹
- The proportion of women who felt that they were left alone at a time that worried them during labour and birth ranged from 0% to 21% across trusts.²
- Of those women who raised concerns during birth and labour, 1 in 5 (19%) of women did not feel their concerns were taken seriously.³
- Only 16% of labouring women reported having one-to-one midwife care, just over a third had two midwives, with 26% having four or more midwives caring for them.⁴
- 85% of women reported not having previously met any of the midwives caring for them during labour and birth.⁵
- Labour started naturally for 60% of women. However, for those women that were induced, nearly half (45%) were not offered a choice about the induction.⁶
- 85% of women felt that they were always treated with respect and dignity during labour and birth, with some variation by place of birth⁷

NHS Charges for Maternity Care

In the UK migrant women can be charged for maternity care and are often charged up to 150% of the cost of their care [according to the BMJ](#). Charging migrant women for NHS maternity care is proving harmful and is leading to poor outcomes for women and their babies.

[Maternity Action's](#) 2018 report [What Price Safe Motherhood? Charging for NHS Maternity Care and Its Impact on Migrant Women](#) further highlights that current legislation is unworkable, unjust and harmful to women, especially those who are living in poverty, destitute, or unable to work. The report states:

'Charging has a deterrent effect on women's access to maternity care which poses risks to their pregnancies and the health of their babies. Anxiety about charging has an adverse effect on maternal mental health with consequent effects on women's pregnancies and pregnancy outcomes. Although all maternity care is designated as immediately necessary, this does not compensate for the anxiety women feel knowing that they are unable to repay very high charges.'

The UK Government held a consultation on the extension of charging overseas visitors and migrants using the NHS in England to which we responded along with multiple organisations, individuals, professionals and professional bodies. The [government response](#) to the consultation in February 2017 stated:

¹ CQC Maternity Survey 2013. See slides 78-79 and 144-147 for more information

² CQC Maternity Survey 2013. See slides 78-79 and 144-147 for more information

³ CQC Maternity Survey 2013. See slides 78-79 and 144-147 for more information

⁴ NPEU Safely Delivered: a national survey of women's experience of maternity care 2014.

⁵ NPEU Safely Delivered: a national survey of women's experience of maternity care 2014.

⁶ NPEU Safely Delivered: a national survey of women's experience of maternity care 2014.

⁷ CQC Maternity Survey 2013 and HSCIC Hospital Episode Statistics.)

'Having considered the views put forward, we intend to proceed with the extension of charging overseas visitors for most NHS services they can currently access for free, although this will be taken in a staged approach.'

We do not consider this response acceptable; women's rights to healthcare will not be adequately protected. Charging for care must be immediately suspended and we fully support Maternity Actions series of recommendations to protect women's rights to reproductive health care.

Other policy initiatives

In November 2017, the Secretary of State published ['Safer Maternity Care'](#) which aimed to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2025 (brought forward from the target of 2030 set in 2016).

The ambition to deliver safer care can sometimes be interpreted as needing to restrict women's choices. However leaders of the Maternity Transformation Programme have been clear that safe care and personalised care are two-sides of the same coin. Indeed the Secretary of State's introduction to 'Safer Maternity Care' contained the following (drafted by Birthrights):

'I believe that safe care is personalised care. There is good evidence that women who have 'continuity of carer' throughout pregnancy and one-to-one support in labour have safer outcomes for themselves and their babies. We need to provide women with the resources and support to make informed decisions and train clinicians to have individualised care planning conversations which uphold women's autonomy and meet their individual needs (including during labour where this can become more challenging when circumstances change quickly).'

In 2016, the Government also announced a much needed £365m investment in [specialist perinatal mental health services](#) over 5 years focused on building capacity and improving early access to specialist mental health services.

In March 2017 a new [employer-led model of supervision](#) for midwives was introduced. The previous system was not without issues but Supervisors of Midwives did have a degree of independence as part of their regulatory role. Women who had difficulty having their voices heard, or their wishes respected, were often supported by Supervisors of Midwives. The new role of Professional Midwifery Advocate (PMA), is slightly different. PMAs do not necessarily deal with women directly - the idea is that they help all the midwives reflect on their practice, and develop skills such as making more complicated birth plans with women, if required.

A-EQUIP and the PMA system is part of the NHS standard contract but how it is enacted is decided by the employer. This allows for different organisations to organise their PMAs differently to suit local need. Early trials of implementing A-EQUIP have emphasised the importance of partnership working, putting mothers and babies at the centre, and the importance of supporting and valuing midwives to give safe and compassionate care.

Whilst the Operational Guidance for the new system of supervision contains some of the strongest statements available of a woman's right to make her own choices and of midwives to support her even if they disagree with her choice, there is some anecdotal evidence that some midwives feel less able to support women to make choices that fall outside of usual guidelines as a result of this change. An evaluation of the new system is in progress and the concern is that standards vary regionally.

Finally on 7 January 2019, the Government published its [long term plan for the NHS](#). The maternity and neonatal elements of the plan largely restated current commitments outlined above.

1. Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth. If so, please specify what kind of cases and describe your country's response and any good practices, including protection of human rights

WRA UK (in collaboration with City of Sanctuary Maternity Stream, Solace and the Refugee Council) heard the stories of migrant women in the UK who are facing giving birth in a hostile environment, as part of a project called ['Women from the Shadows'](#). We have included their voices below and believe their experiences demonstrate denial of rights to healthcare, abuse and mistreatment in pregnancy and childbirth faced by migrant women in the UK.

Barriers to Accessing Reproductive Care

Helena*

Helena faced discrimination and struggled to access GP care. Helena told us that she was denied registration by a receptionist when she was entitled to access care:

"She asked for one document that it's really not exist and I said it's same [sic] for mum and kids it's all included in same [sic] document and she said 'no I want this document', but we don't have that document, because the Home Office don't send us to each person... She said, 'no I'm sorry I can't accept you here. If you want to claim here you have to bring this document' ...and it was the second time when I went to the GP and always I can see they show their racism to people who is [sic] an asylum seeker"

Mistreatment during facility-based childbirth

Pregnant migrant women are often vulnerable during their pregnancies and while trying to access care; WRA UK heard from women who weren't given access to translators at birth facilities and therefore weren't able to give informed consent to procedures they underwent.

Diana

Diana was never informed that she was entitled to midwifery care, despite visiting a GP and she wasn't provided with an interpreter when she went into hospital:

"I got to the hospital with my friend who was the one who will be translating for me, but she could only stay for a few hours because after that she had to go to work. I thought it would be a few hours, but I ended up staying there for three days...three full days of pain, horrible pain. It was long hours, like six, seven hours without anyone to translate anything and with all the pain and the nurses, they were all changing shifts every eight hours, so it was pretty much zero communication. I remember I wanted to die, I felt like I was dying, the pain was so horrible, and I didn't have anyone to tell me that that was normal, I thought that wasn't normal. I remember the third day, after being totally exhausted, I just couldn't suffer anymore. Then I was told I could get epidural, something for the pain, I didn't know exactly what it was, so I just say OK, whatever works now!"

Diana tried to communicate with staff in the hospital and told WRA UK that nurses used gestures to communicate rather than finding translation services:

"The thing I got from the 'sign language', that they used, could talk to me, it was like I was supposed to go into cesarean. When the doctors were doing all the paperwork, you know in a hospital room they just go in and out, in and out, and you have no idea what is going on. And then there was this nurse, and she just came and just with her hands pushed the baby, just put the baby into the position she should be, and just pushed her out, with no cuts or anything, and the baby was halfway out, and it was just horrible. They said they need to cut the waters, but I didn't understand what they were saying, they said keep pushing."

Marie*

While at the hospital with her premature baby, after being rushed into a c-section, Marie didn't fully understand what was happening or why they had done the surgery; she became very depressed, and did not have an interpreter to help her understand the medical explanations she was given:

"...the doctors are doing their job, it's medical, most of the time when they explain you don't understand nothing, especially for someone like me, that English is not their first language, like no English, I struggled to understand some words, imagine, medical English".

Fear of immigration authorities is leading women to give birth alone. Marie told us:

"I knew a woman, a friend of mine, who during her pregnancy didn't have any visit, any consultation with a midwife because she was scared to go and register or to see one. Just imagine a woman who doesn't speak the language, or even who speak the language, going to the hospital with a contraction having this pain; even before the pain you weren't in control of everything, now with the pain".

Every Word Counts

Make Birth Better's ['Every Word Counts' campaign](#) has found that the language used towards women in pregnancy, birth and postnatally leads to the perception that they are restricted in what choices they can make regarding their bodies, babies and their care. Phrases such as "you are not allowed to...", "who told you you could...?" and hundreds of other negative statements are routinely made towards women, which takes away their agency and promotes fear, and makes their birth experience subject to value based judgements. Women who are not respected and allowed a voice during pregnancy and birth will not have the best outcomes or experiences.

Birth Trauma and Mental Health

Birth trauma is a huge issue that is often not well recognised or diagnosed, it affects over 200,000 women per year in the UK and 1 in 25 women develop Post Traumatic Stress Disorder (PTSD) after childbirth.

Asylum seeking, refugee and migrant women are particularly vulnerable during pregnancy and childbirth. Our organisations have heard the stories of many pregnant migrant women in England fearing forcible removal or detention while pregnant, or are suffering from isolation and poverty while trying to care for their babies. Tabita told WRA UK that she had struggled with her mental health after giving birth as a migrant in a new country,

“When you become isolated, you just stay inside the room because of the fear and you don’t talk to the people. It affects [you] mentally, you know, always negative, fear, fear, fear”.

Janine* told WRA UK,

“No one was there to help me, it was the first time. I needed someone to speak to, someone who can encourage me and say, no it’s going to be ok, but I didn’t.”

Rihana* faced daily fear over possible deportation while pregnant and in need of prenatal care,

“So your life is like, in danger, so at any time they will come to take you”

Diana has suffered severe mental health issues due to her traumatic experiences during pregnancy and particularly childbirth as a migrant woman in the UK:

“There is no way in the world that I will ever go through a pregnancy again, no way, no way. Obviously, I want more children, but I just don’t feel like I will be mentally or physically able to do it.

...I found myself in a position where I can’t feed my daughter. I have to go and sign to the Home Office, but I have no money to go and sign to the Home Office. I just took some sleeping tablets that I’ve got because I wanted to sleep, you know, I’ve just got too many things going on in my head, so I just took a few tablets and go to sleep, until I woke up a couple of days later at the hospital.

You totally lost the sense of your personality, because you believe that you are not allowed to do anything and wherever you will go this sense of blaming yourself will go with you so will prefer instead of giving your name, just giving your reference number.”

Birth Trauma was added to the National Institute for Health and Care Excellence (NICE) [guidelines](#) on PTSD, but it has yet to be added as an independent category. There is still much more to be done to get birth related PTSD and maternal mental health on the national policy agenda.

Women with Disabilities

Birthrights, in response to indications in their 2013 study that disabled women might be facing particular human rights issues in maternity care, commissioned Bournemouth University to undertake quantitative and qualitative research in this area. The [final report](#) into this research was published in March 2018. A survey of women with physical or sensory impairment or long term health conditions highlighted that these women:

- received inadequate information about their choices more often than other women;
- were unhappier with the availability of pain relief;
- felt they had less choice and control over their birth experiences;
- felt that their rights were poorly or very poorly respected;

Only 19% of women (2018) thought reasonable adjustments had been made for them and some found birth rooms, postnatal wards, or their notes and scans “completely inaccessible”.

Most strikingly, more than half (56%) felt that health care providers did not have appropriate attitudes to disability.

Just over half of the participants expressed dissatisfaction with one or more care providers, particularly their awareness of the impact of disability and their perception that their choices in pregnancy and birth were being reduced or overruled. One participant with a physical impairment and a long-term health condition stated, *“No one understood my disability. No one knew how to help or who to send me to for support.”* Another added, *“I didn’t have any control or any choice. Everything was decided for me.”* And one woman said, *“They did not listen to me. I advised them on the unique way my body works. They did not listen to my advocates.”*

Enquiries to the Birthrights advice line support the impression that maternity care in the UK is not well equipped to offer individualised care, particularly where women do not fit easily into a prescribed care pathway. These guest blog posts from [Hayley](#) and [Emma](#) demonstrate the experience of two women with autism. Hayley’s specific needs for a positive birth experience were ignored, she said:

“However, my birth plan suggestion of ‘no lights, no music or shouting’ was ignored. Coupled with problems in initiating conversation, this gave an overall sense that I was lacking any choice, any dignity over my pregnancy and baby. ‘The NHS owns this pregnancy, not me’ was something I remember telling my husband during the first precious days at home after birth.”

Emma found her birth experience traumatic, something which stayed with her long after giving birth:

“...there was wonder and amazement. But there was also unrelenting, overwhelming pain, anxiety, trauma and a thick layer of fog and disconnect that did not dissipate magically and completely. No, instead it stayed with me, as I tried to orient myself in a new and terrifying world, surrounded by people that did not understand me or respect my needs and wishes, that at best were dismissive and at worst openly hostile. It stayed and coloured the moments I laid eyes on my beautiful daughter, it stayed and infiltrated the days, weeks and months after her birth.”

2. Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care

Legal Context: Informed Consent

The English legal system protects the principle of consent in a number of ways. In the common law (the part of English law that is derived from judicial precedent), non-consented medical treatment constitutes the crime of battery and the tort of trespass to the person. An individual who has been subject to medical interference against their will can bring a civil action for damages. A caregiver could also be deemed negligent if they failed to obtain a person's consent to treatment. In addition, the rights under the European Convention on Human Rights are incorporated into England law through the Human Rights Act 1998. Informed consent is an essential element of Article 3 (right to be free from inhuman and degrading treatment) and Article 8 (right to private and family life).

The courts have made it clear that pregnant women have equal status in the law and the same entitlement to protection from unwanted treatment. In *S v St George's Healthcare Trust* (1998), the Court of Appeal considered the case of a woman detained under the Mental Health Act 1983 who was suffering from pre-eclampsia and had refused a caesarean section. The High Court ordered that the operation should be performed to save the lives of mother and baby. The woman later appealed to the Court of Appeal. Its decision forcefully asserted the right of pregnant women to decide for themselves whether to undergo medical treatment:

"...while pregnancy increases the personal responsibilities of a woman, it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human and protected by the law in a number of different ways ... an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant."

The case resolved any question about the necessity for consent for medical treatment from pregnant women in English law. Women with mental capacity cannot be compelled to accept any form of medical care or treatment during pregnancy and birth.

In 2015, the UK Supreme Court gave a landmark judgment on informed consent in *Montgomery v Lanarkshire Health Board* (2015). Mrs. Montgomery, a pregnant diabetic woman with a large baby, was not informed by her obstetrician of the chance of shoulder dystocia and her baby was damaged during birth. The Court held that clinicians must adopt a woman-centred approach to advice giving during pregnancy. It deprecated the use of consent forms and information leaflets and held that the law required clinicians to have detailed and personalised discussions with women that enabled them to make their own decisions on the basis of information about 'all material risks'. The Court explained that it was necessary to impose legal obligations of this sort, so 'that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion which the law requires.' The Montgomery decision underlines that the law demands individualised, not institutionalised, care.

On the whole the policy and legal context in the UK is benign and supportive of rights respecting maternity care and in line with WHO standards. It is hard to find a policy document or a regulatory framework that does not reflect these values. Despite this, there is evidence that too many women in the UK are experiencing maternity care that does not respect their basic rights. Strain on under-resourced maternity services, a culture of excessive emphasis on clinical policy rather than individualised care, and

misunderstanding of basic legal responsibilities, all contribute to poor quality care than can lead to violations of women's dignity and autonomy.

Unconsented vaginal examinations

Birthrights has been contacted by a number of women through our advice service who have given their accounts of being given vaginal examinations without consent. We presented a paper to a conference exploring the legal framework around this issue in February at Exeter College, Oxford.

Birthrights are concerned that this behaviour does not have a clear route to redress. Maternity notes are often not as detailed or accurate as they should be (formal complaints generally come to nothing if the notes or accounts from hospital staff do not match the woman's account even if there are other witnesses), the police can be reluctant to interfere in something that they perceive as a medical matter, regulatory bodies want to see evidence that the behaviour is repeated and not just the result of a misunderstanding before they will investigate, and Birthrights are not aware of any legal claims in this area to date. Birthrights is planning some further work on this issue.

Dignity in Childbirth Survey 2013

Women's Perspectives

In 2013, Birthrights carried out the [Dignity in Childbirth Survey](#) to obtain a better picture of women's experiences of maternity care. We wanted to know how far the legal position around protection of consent in UK law matched the reality of childbirth in the UK.

Overall, 12% of respondents of our survey (of over 1000 women) considered that they had not given their consent to examinations or procedures. Respondents said that consent was obtained more frequently in birth centres than in hospitals. 93% of respondents considered that their consent had been obtained before examinations and procedures in birth centres, while 77% of respondents reported that their consent had been obtained in hospital.

It was more common for consent not to be obtained from first-time mothers (16%) and for women who had an instrumental birth (24%). Failure to obtain consent was only slightly higher for women who had a CS (14%).

Respondents gave similar answers to the question about whether information had been provided before an examination or procedure. 11% of respondents overall considered that they had not been given information about each examination or procedure before it had been performed. This figure was higher for first-time mothers (15%) and in relation to instrumental births (23%).

Healthcare Professionals' Perspectives

Birthrights conducted qualitative interviews with midwives as part of the Dignity in Childbirth study. There was a consensus amongst the midwives we interviewed that maternity care practitioners practice had greatly improved in gaining consent (particularly for vaginal examinations) and that it was now rare to fail to obtain consent. However, midwives did recount incidents where women's consent had not been granted and there was discussion of further improvements that could be made in how consent was sought from women.

'I have seen the other extreme where there's been absolutely no mention of what's going to happen and women's bodies have been touched without any consent whatsoever and in two cases I've seen women being held down to have interventions performed on them.'

- Daniella

Participants discussed how a culture of expected compliance permeated through the maternity care system which led to assumptions that women would just go along with routine care plans. This was visible in the language used to present examinations and interventions as simply being routine parts of normal care and failing to give any indication that women could decide to opt out of them. Induction of labour was frequently cited as an example of this:

“Often you see the word offer, induction was offered, something was offered, but it’s not offered really, I mean if there’s an offer there’s an assumption that someone has an option to say “ooh, thank you very much but no I won’t thanks”, whereas actually that’s not really what’s meant at all.”

- Polly

Women who were not compliant and questioned or refused recommended interventions generated gossip amongst maternity care providers and were prone to be labelled as awkward or difficult.

“Women are made to feel so terrible if they don’t conform, and they’re talked about within the staff room, you know ‘I can’t believe she hasn’t done that’ or ‘I can’t believe she has done this’. If you don’t conform you are in a way stereotyped into being a bad woman.”

- Student midwife

Simple language was seen as crucial to consent gaining for clinical treatment. For example, asking permission to perform vaginal examinations in an abstract way, saying things such as ‘examine you down below’ was regarded as too vague and potentially open to misinterpretation.

In contrast, being direct and succinct was considered a better way of enabling women to understand exactly what they were being asked to consent to. For example, saying: ‘I need to put my fingers inside your vagina. Are you happy for me to do that?’.

RCM’s [Caring for You](#) campaign, which asked each maternity unit in the UK to commit to taking action to support midwives and maternity support workers health and wellbeing. There are currently high levels of stress and burn out amongst midwives and maternity support workers, and staff shortages and heavy workloads are driving some midwives to leave the profession. Understaffing has also contributed to low levels of staff engagement, which has been shown to negatively affect patient outcomes. Since launching the campaign in 2016 142 NHS organisations have signed the campaign charter, committing to work collaboratively with the local RCM representatives to improve the health, safety and wellbeing of midwives and MSWs.

3. Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations

NHS Accountability

The NHS Constitution guarantees every patient in England the right to make a complaint about NHS services and the NHS is bound by a statutory complaints procedure.

Anyone who is not satisfied with their NHS care can complain directly to the care provider or the commissioner of the service (normally the local Clinical Commissioning Group). The complaint should

be acknowledged within 2-3 working days and a response completed within six months unless there are extenuating circumstances.

If the complainant is not satisfied that the complaint has been satisfactorily resolved, they can make a complaint to the Parliamentary and Health Service Ombudsman (the PHSO). The devolved nations have their own Ombudsman arrangements. The PHSO will normally only look at a complaint after the local complaints process has been exhausted. The PHSO will take the human rights context into account. Their website states that:

“In applying the Principles, we will also have regard to the human rights context. Taking account of basic human rights principles of fairness, respect, equality, dignity and autonomy may, in certain cases, add weight and gravity to our findings.”

A complaint can also be made to the regulators for the profession if the complaint relates to the behaviour or practice of an individual. The relevant regulators are the General Medical Council (GMC) for doctors and the Nursing and Midwifery Council (NMC) for midwives.

Finally, there is the option of making a legal claim. However, in practice it is very lengthy and costly to make a human rights claim unless there is a significant clinical negligence element to the claim, in which case some firms will offer a conditional fee arrangement.

How Do These Mechanisms Work in Practise?

We are fortunate in the UK that these accountability mechanisms exist.

However they are not perfect. Within Trusts complaint investigations are often undertaken by junior staff without the power to challenge senior medical staff.

By the time women and their families have gone through the local complaints process, they are often exhausted and fed up, and many women who have contacted us, have not proceeded to the Ombudsman even though their complaint has not been resolved.

Birtherights have reported a number of situations where the notes are either scant or directly contradict what the woman reports has happened (for example, by saying, “consent given” when the woman doesn’t feel she gave consent). There are also circumstances where notes go missing. In these circumstances it is very difficult for a complaint to be progressed.

One of Birtherights’ main concerns about the complaints process in recent years has been the use of expert witnesses by regulators and the Ombudsman who do not appear to have a good understanding of human rights law. For example, one woman who complained to the GMC about two unconsented vaginal examinations, and where the expert witness seemed to imply this was ok in an emergency situation despite the woman being able to shout “no consent” repeatedly. Similarly, an expert witness, used by the Ombudsman, who did not appear to have much experience of working in a birth centre, advised that a birth centre was entitled to refuse a woman who was older than the birth centre guideline parameters without giving a good reason, which we would disagree with.

Birtherights has raised these concerns with all these organisations and the Ombudsman and NMC in particular have been much more open recently to hearing feedback and working with outside organisations such as ourselves.

NHS Staff Perspectives

The [National Review of Maternity Services: Assessment of Quality in Maternity Services](#) found from NHS health professionals themselves that there is much room to improve reporting and accountability mechanisms to benefit women, children and health workers themselves:

- 94% of midwives think that their organisation encourages staff to report errors, near misses and incidents, compared to 85% for all other NHS occupations.⁸
- 22% of midwives think that people are blamed or punished for being involved in errors, near misses or incidents, compared to 14% for all other occupations.⁹
- 75% of midwives think that when incidents are reported, their organisation takes action to ensure that they do not happen again, compared to 62% for all other NHS occupations.¹⁰
- Around 12% of midwives and 11% of all other staff said they would feel insecure raising a concern about unsafe clinical practice.¹¹
- Almost half of midwives had witnessed potentially harmful errors in 2014, while the figure for nurses was 36% and for all NHS staff was only 28%.¹²

Maternity Claims

Maternity claims represented the second highest number of claims against the NHS between 2000 and 2010, totalling 20% of all claims and 49% of the total value of all claims at £3.1 billion.

- In birth injury claims, the claimant must establish a causative link between the alleged breach and the damage, otherwise the claim will fail.
- Less than 0.1% of births lead to claims, but the value of these claims is high as birth injury can result in lifelong disability.
- Most claims relate to issues with management of labour, caesarean sections or cases of cerebral palsy.

4. Does your health system have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue

In 2016 NICE issued guidelines on [Domestic Violence and Abuse quality standards](#) for England and Wales. The guidelines covers domestic violence and abuse in adults and young people aged 16 years and over, who are experiencing (or have experienced) domestic violence or abuse, as well as adults and young people perpetrating domestic violence or abuse.

In 2017 the UK Government released guidance for health professionals on domestic abuse titled [Domestic abuse: a resource for health professionals](#), in order to help health professionals to identify potential victims, initiate sensitive routine enquiry and respond effectively to disclosures of abuse.

The Royal College of Midwives works to promote professional practice in midwifery and has [released a number of resources](#) for midwives on dealing with violence against women. The RCM has published their [position on violence against women](#) stating that,

‘Violence Against Women and Girls (VAWG) in any form is a hate crime and a violation of their Human Rights. Midwives and the maternity services have a duty to support each and every individual who seeks help as a result of VAWG, treating them with compassion, respect and dignity.’

⁸ Source: NHS Staff Survey 2014 – Errors, Near Misses and Incidents - 4785 midwives responded, representing ~2% of all staff who completed the survey (although there is question-level variability in response numbers).

⁹ Source: NHS Staff Survey 2014

¹⁰ Source: NHS Staff Survey 2014

¹¹ Source: NHS Staff Survey 2014

¹² Royal College of Midwives analysis of NHS Staff Survey 2014 responses from midwives.

NHS Scotland has set out [comprehensive guidance](#) for dealing with gender based violence and in 2009 released guidance on [Gender based violence: what health workers need to know](#). In 2014 NHS Highland and Police Scotland released guidance for a [multi-agency response to violence against women](#). The framework sets out how the Highland Public Services Partnership will address Violence Against Women (VAW). This included actions for improving safety for those affected, improving services and taking steps to prevent future VAW as well as dealing effectively with perpetrators of VAW.

In 2016 in Northern Ireland the Department of Health, Social Services and Public Safety and the Department of Justice released a seven year strategy to tackle domestic and sexual violence and abuse titled [Stopping domestic and sexual violence and abuse in Northern Ireland](#). The guidance outlines the national goal to eliminate domestic and sexual violence and effective tailored preventative and the provision of effective responsive services, and with all victims supported, and perpetrators are held to account.

The Royal College of Nurses has also provided a [comprehensive list of guidance](#) on violence against women across UK countries for the benefit of health staff.

Other Supporting Evidence

Maternal Request Caesarean

Birthrights published a [report on maternal request caesarean](#) last year which showed that only around a quarter of Trusts had a policy in line with the relevant NICE guideline in the UK, which states that as long as a woman is making an informed choice, ultimately she should be offered a caesarean if she requests one, although individual obstetricians can refer to another colleague if they are unable to support the request. The report highlighted that the number one reason women contacting our advice service asked for a caesarean was a previous traumatic birth. Other reasons included underlying medical conditions that women feared would be exacerbated but that didn't reach the threshold for a medical caesarean, and previous sexual assault or trauma.

We remain concerned that it appears to be acceptable for a woman's request to be refused and for the woman simply to be left anxious and unhappy and facing a vaginal birth that is not acceptable to her.

Out of Hospital Birth

There is currently no statutory entitlement to out of hospital birth in the UK but there is strong policy and research support for developing more accessible out-of-hospital birth services, which is happening in some areas. However Birthrights continues to receive reports of both home birth services and birth centres in some areas being under-staffed, under-promoted, regularly suspended or withdrawn.

It is clear that although birth centres, particularly freestanding ones, are well loved by women who use them, if there is not a well thought out plan for keeping them economically viable, and for promoting their use, they can be easy targets for Trusts needing to cut costs. The Maternity Transformation Board/NHS England are aware of this issue, but is currently of the view that these matters need to be dealt with at a local level. There have been some prominent closures of freestanding birth centres in the last eighteen months.

Birthrights has had a small number of disturbing reports in the last eighteen months or so in relation to home birth policies, some of which can be very restrictive in terms of criteria, despite the fact that women cannot be compelled to go to hospital and midwives having a duty of care to attend when they

have been notified of a woman's wish to give birth at home. In one case a Trusts' homebirth policy required women to sign a contract which implied that they would need to agree to whatever intervention a midwife proposed if they had a home birth, which clearly was not compatible with respecting a woman's autonomy.

Research on Women's Experiences in other UK Countries

Wales: Your birth, We Care 2017

<https://gweddill.gov.wales/docs/phhs/publications/180116your-birthen.pdf>

Scottish Government Maternity Care Survey 2018

<https://www.gov.scot/publications/maternity-care-survey-2018-national-results/>

Research on Vulnerable Women's Experiences of Pregnancy and Childbirth

Pregnant women in detention. Please note since this report, pregnant women can be detained for immigration purposes for only 72 hours, extendable only on ministerial discretion

<https://detentioninquiry.files.wordpress.com/2015/03/immigration-detention-inquiry-report.pdf>

Care of pregnant Asylum Seekers in the UK

<https://obgyn.onlinelibrary.wiley.com/doi/10.1111/tog.12224>

Dispersal of pregnant asylum seekers

https://www.maternityaction.org.uk/wp-content/uploads/2013/09/When_Maternity_Doesn_t_Matter_-_Ref_Council_Maternity_Action_report_Feb2013.pdf

The Incarcerated Pregnancy: An Ethnographic Study of Perinatal Women in English Prisons

<https://uhra.herts.ac.uk/handle/2299/20283>

Experience of women in Cumbria

<http://www.northcumbriaccg.nhs.uk/news/2016/February/hw-maternity-matters-final.PDF?ContensisTextOnly=true>

Access to maternity care for pregnant women in Europe

Doctors of the World: Obstacles in Access to Care for Children and Pregnant Women in Europe

<https://mdmgreece.gr/app/uploads/2015/05/MdM-Intl-Obs-2015-report-EN.pdf>

Medical Colleges criticise charging migrants upfront for NHS care

<https://www.theguardian.com/politics/2018/dec/20/medical-colleges-criticise-charging-migrants-for-nhs-care>