Submission to the Citizens' Assembly

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1. INTRODUCTION: The Impact of the Eighth Amendment on all aspects of maternity care in Ireland

Article 40.3.3 of the Irish Constitution (the Eighth Amendment) enshrines the equal right to life of the woman and foetus. In practice, however, this has meant that the foetus takes precedence. The impact of the Eighth Amendment, beyond restricting abortion rights, is substantial and far-reaching, affecting the fundamental human rights of every woman in pregnancy and childbirth, denying her rights to bodily autonomy and informed decision-making in relation to medical care and treatment that are recognised in every other aspect of her life.

Arguably, in voting for the Eighth Amendment in 1983, the people understood that they were voting about abortion only. However, the language of the Eighth Amendment itself, which refers to the 'life' of 'the unborn', has been interpreted to bring the duration of pregnancy, labour and birth within the Amendment's reach. The Eighth Amendment directly impacts on the right to choice in childbirth of some 70,000 women giving birth annually in Ireland. As such, pregnant women are the only group of competent decision-making capacity excluded from the National Consent Policy of the Health Service Executive[1], which stipulates:

> *"The consent of a pregnant woman is required for all health and social care interventions. However, because of the Constitutional provisions on the right to life of the "unborn" (Article 40.3.3 of the Constitution of Ireland 1937), there is significant legal uncertainty regarding the extent of a pregnant woman's right to refuse treatment in circumstances in which the refusal would put the life of a viable foetus at serious risk. In such circumstances, legal advice should be sought as to whether an application to the High Court is necessary."*

The duty, emanating from the Eighth Amendment, on the medical profession to vindicate the state's interest in protecting the foetus, even over the objection of a competent and unwilling pregnant woman, gives rise to incentives in a context of imbalance of power and information between the doctor and the pregnant woman. The problem is significantly compounded for women whose approach to health and risk-limitation diverges from the reductionist medical view. For the woman who makes an informed decision to refuse medical intervention in the interests of her own and her baby's health and safety, the national consent policy denies her the opportunity to guard and protect herself and baby.

While the Eighth Amendment is by no means the only contributing factor to a culture where meaningful informed choice and human rights in pregnancy and childbirth are not properly observed, it is the single greatest obstacle to the realisation of this and hence to the attainment of the highest level of health that is the right of every pregnant woman for herself and her unborn baby.

In falsely and divisively creating a separation between the mother and her unborn, the Eighth Amendment sets both up as having competing interests. This is patently not the case for women in continued pregnancy, who have the best possible outcomes for themselves and their unborn baby to the fore of their thinking at all times. It is this vitally important reality that is crudely eroded by the Eighth Amendment, in forcing an impossible divide in a relationship that is in fact inseparable. It

is through the mother exercising her right to dignity, autonomy and choice, that the achievement of the best possible outcomes is possible for both the mother and baby together.

Unsafe abortion is one of the five leading causes of maternal mortality globally.[2] Midwives for Choice supports repeal of the Eighth Amendment, and liberalisation of Ireland's abortion law, in the interest of safeguarding the lives and health of women living in Ireland who choose abortion. This submission is, however, confined to discussing the impact of the Eighth Amendment in undermining the safety and health of women, and their babies, who choose to continue their pregnancy.

2. AN OVERVIEW OF THE ADVERSE IMPACT OF THE EIGHTH AMENDMENT IN LABOUR AND BIRTH

Pregnancy and childbirth are momentous events in the lives of women and families, representing an important rite of passage with deep personal and cultural significance for a woman and her family. Because motherhood is specific to women,[*] issues of gender equity and gender violence are also at the core of maternity care.

A woman's relationship with maternity care providers and the maternity care system during pregnancy and childbirth is vitally important, at a time in her life when her identity as a mother is being forged. Not only are these encounters the vehicle for essential and potentially lifesaving health care, women's experiences with caregivers at this time have the impact to empower and comfort or to inflict lasting damage and emotional trauma, adding to or detracting from women's confidence and self-esteem. Either way, women's memories of their childbearing experiences stay with them for their lifetime and are often shared with other women, contributing to a climate of confidence or doubt around childbearing.

Imagine the personal treatment you would expect from a maternity care provider entrusted to help you or a woman you love give birth. Naturally, we envision a relationship characterized by caring, empathy, support, trust, confidence, and empowerment, as well as gentle, respectful, and effective communication to enable informed decision making. Unfortunately, too many women experience care that does not match this image. Our approach to maternity care and key elements of the outcomes achieved provides an insight into the effect of the Eighth Amendment in copper-fastening the domination and control of women in childbirth and the injustice it levels at vulnerable pregnant and birthing women simply seeking to get the best possible outcome for themselves and their babies.

This section outlines the current landscape in maternity services in Ireland, and will explore the impact of the Eighth Amendment into an unsustainable and damaging system of maternity care that is predicated on a lack of meaningful informed consent or refusal for women, and appropriate choice.

[*] While we use 'woman' throughout this submission, we recognise that not everyone who is pregnant is a woman

2.1 Caesarean section

Despite the fact that as many as 80-85 per cent of women are healthy in childbirth, Ireland's maternity care system is modelled on specialist obstetric care in hospitals for pregnant women. As health care budgets career out of control, the economic and social costs of this centralised model of maternity care for physiological birth have become unsustainable.

Within the specialised, hospital care model, efficient progress in labour is necessary for processing large numbers of birthing women to avert a labour ward bottle-neck. This has led to high levels of unnecessary and costly medical intervention.

Increases in the use of Caesarean section (CS) have been particularly steep in recent decades leading to concerns about the benefits of CS being outweighed by the increased clinical risks and higher costs relative to vaginal delivery. In Ireland the proportion of total births delivered by CS increased four-fold from 7.4 per cent in 1984 to 29.8 per cent by 2014[3], thus, almost 1 in 3 women give birth surgically today.

The World Health Organisation defines CS rates over 15 per cent as an 'excess' and 'over-use', and urges countries with levels over this rate to take action to address it.[4] From a risk management perspective, there is good reason for concern. While maternal death is a rare event, CS can be life-threatening. Unnecessary CS are those which are done in the absence of any underlying medical problem. The evidence on this category of CS shows the risks involved in the operation and consequently the imperative of concerted efforts to address over-use of the procedure. Compared to spontaneous vaginal birth, elective (pre-labour) and intrapartum (in-labour) CS, without medical indications, has been shown to be associated with increased risk of death, admission to intensive care unit, blood transfusion and hysterectomy.[5] An insight into why our CS rate in a population of predominantly healthy women is double that recommended by the WHO is gleaned from the approach to managing birth in our hospitals.

2.2 Electronic fetal monitoring

Routine medical intervention in the normal physiological process of birth sets in train a domino effect, inevitably leading to a proportion of iatrogenic damage. The routine use of electronic fetal monitoring is commonplace in Irish hospitals. Electronic fetal monitoring limits women's mobility, including the option of using a shower/bath, to help with comfort and control during labour, thus increasing the need for pharmacological pain relief. Evidence shows no benefit of electronic fetal monitoring over intermittent monitoring for the healthy mother with a healthy baby. On the contrary, it shows an association with significant increase in CS and instrumental births,[6] due to erroneous interpretation of the produced fetal heart graph. In this context, denying a healthy woman in labour the right to refuse routine electronic fetal monitoring in accordance with hospital policy denies her the right to guard and protect herself and her baby. In a survey of women's experiences of maternity care, involving 2836 women, conducted in 2014 by AIMS Ireland, entitled 'What Matters to You'[30] the following comments show the effect of the Eighth Amendment in practice:

"I was instructed that I wouldn't have the option to refuse monitoring during labour. I wanted the option to refuse monitoring (FHM) [fetal heart monitoring] during labour to move around and be more mobile if I desired."

"A fetal scalp electrode was applied to my baby and an arm [artificial rupture of membranes] was performed without seeking consent. The only reason I was told the fse had been applied was because I noticed the different sound of the fhr beat on the ctg."

"I was told I had no choice when it came to my treatment, everything was 'hospital policy'."

2.3 Induction and acceleration of labour

Induction of labour continues to be common, as does the practice of acceleration of labour. In 2014, the induction rate at the Coombe hospital in Dublin was 31 per cent, significantly increasing the risk of CS for first-time mothers; the rate among those who laboured spontaneously was 10.6 per cent, rising to 31.2 per cent among those whose labour was induced.[7]

Both induction and acceleration of labour are accomplished by means of the same drugs and/or interventions. Amniotomy is used both to induce and to accelerate labour by strengthening and speeding up contractions; it involves puncturing the membranes enclosing the protective waters surrounding the baby in the womb with an instrument resembling a crochet hook. While the evidence does not support its routine use as part of standard labour management and care,[8] 52.4 per cent of women giving birth at the National Maternity Hospital in 2009 had their waters broken.[9]

The acceleration of labour is a cornerstone of the 'active' management of women in labour. Active management is a set of obstetric protocols standardising the medicalisation of birth for efficient labour ward management, comprising early amniotomy and the administration of oxytocin by intravenous drip. The response to oxytocin is highly idiosyncratic. Its American manufacturers, Parke-Davis, advise that the response depends on the sensitivity of the individual woman and consequently recommend fetal scalp electrode monitoring lest contractions become too powerful or too prolonged either for the baby or for the mother. Likewise, the WHO warns that the acceleration of labour "*should be performed with caution as the procedure carries the risk of uterine hyperstimulation, with the potential consequences of fetal distress and uterine rupture"*.[10]

Clearly, if women are aware of these risks associated with induction of labour and its acceleration, some may consider them unacceptable. However, the institution relies on its staff to implement policy and on women to comply for its own effective functioning, leading practitioners to pressure or coerce women through risk inflation, threats or selective information provision as the following findings by the AIMSI Ireland survey demonstrate:

"I had to challenge the hospital on everything. Procedures and "policy" were proposed that were against HSE best practice, best practice in UK, US and most of Europe and that have been proven to have NO benefit to mother or baby and only bring increased risks."

"I had to fight tooth and nail not to be induced at 6 days over.. no medical reason to be induced. Just to suit induction days in hospital."

"I felt angry at my full term appointment when i said I didn't want to discuss induction until I was at least 14 days "over". When i said I didn't want a sweep on that day I was asked if I knew the risks involved in not intervening (stillbirth being one). Risks like infections from unnecessary sweeps weren't mentioned."

"The tests they did were as far as I was told compulsory and results were just told to me and options were not discussed, it was their way is best. When we questioned it we were told we were putting our babies life in danger."

"You were made to feel a bad mother if you did not have all the tests."

"Formally yes (consent was obtained), but I wasn't in favour of being induced, it was never presented as an option but rather as a decision made on my behalf."

"I repeatedly impressed my wish not to have oxytocin and this was disregarded and I was treated like I was being silly. I reluctantly agreed but I felt badgered into submission rather than consenting."

"Benefits of procedures to hurry Labour up were told, risks of these procedures were not told. Benefits of waiting were never once told."

"Requested c-section based on 2 previous traumatic births (incl 1 section) but was bullied into natural birth – best for baby."

" I didn't want to be induced but in (unit named) the policy was to induce when 10 days over; I didn't agree with this policy but felt I had no choice but to comply"

"At every intervention I was threatened with catastrophic consequences if I refused such as 'if you don't have an episiotomy right now the baby won't make it'…'if you don't take antibiotics the baby might have cerebral palsy'"

"I was told by the midwife that I had to have my waters broken in order to get an epidural (I found out afterwards this is actually not hospital policy)."

"I felt that I could not say no to anything. You have to put all of your trust in the medical professionals. Sometimes they are wrong."

"When a sweep was suggested at 39 weeks. I refused and then was convinced by doctor to let her do the sweep. Looking back I felt bullied and as I was tired I caved and consented to it"

"I felt I was lied to."

"Consent was sought at all times but I felt pressure that the only option was to agree with what was proposed."

"I wasn't given the opportunity, but I took it because no-one touches me without my consent. I'm one of the hundreds of thousands of women who has survived sexual assault, consent is a massive deal for me. As it should be for every single healthcare practitioner."

2.4 Epidural anaesthesia

Increasing the power and frequency of contractions, the active management of women in labour in turn increases the demand for epidural anaesthesia as women strive to make labour more tolerable. Used in 47 per cent of births at the Rotunda[11], and in 41 per cent at the Coombe[12], epidural anaesthesia is associated with an increased risk of CS for foetal distress.[13] This form of anaesthesia is often accompanied by continuous electronic fetal monitoring, thereby compounding the risk of CS in uncomplicated labour. A legislative and policy framework denying women the right to refuse medical interventional causing increased pain beyond their coping capacity leading to the need for epidural that carries these risks is a framework that significantly undermines the health and safety of the mother and baby.

2.5 The consequences for babies

In normal physiological labour, the baby has a natural capacity to adapt to reduced oxygen supply during uterine contraction, however, intervention that increases the power, duration and frequency of contractions undermines the baby's capacity to cope with the birthing process.

CS is associated with almost double the risk of admission to a neonatal intensive care unit for seven or more days compared to babies born vaginally.[14] At the National Maternity Hospital, where active management was first developed, 1 in 5 newborn babies are admitted to intensive care following birth.[15] Recent research also points to latent risks of CS for chronic disease: children delivered by CS have a higher incidence of type 1 diabetes, obesity, and asthma.[16]

2.6 Breastfeeding

A substantial body of evidence over recent decades has demonstrated the benefits of breastfeeding for babies, mothers and society generally. Maternal benefits include faster involution of the uterus and lower risk of haemorrhage after birth, in addition to a lower lifetime incidence of type II diabetes, and breast and ovarian cancer.[17] Associated infant health benefits include fewer childhood illnesses, lower blood pressure and cholesterol levels, lower prevalence of obesity, and improved intelligence as adults.[18, 19] Reflecting these proven benefits, the WHO recommends that all infants should be breastfed exclusively for the first six months of life, and continue breastfeeding up to and beyond two years of age.[20] The advice also states that, save for a small number of medical conditions, exclusive breastfeeding should be possible for the vast majority of mothers.

Breastfeeding rates in Ireland are well below these targets: 40.8 per cent of Irish-born mothers are breastfeeding at hospital discharge,[21] a rate that is much lower than other European countries.[22]

Research shows that compared to vaginal birth, women who deliver by CS are less likely to initiate breastfeeding, have a higher proportion of difficulties, and are more likely to discontinue before 12 weeks postpartum.[23] This evidence shows the far-reaching health potential of repeal of the Eighth Amendment to enable women in childbirth to assert the right to refuse medical intervention.

2.7 Poor maternal mental health

Evidence has shown that degrading treatment and loss of dignity and control during birth contributes to postnatal post-traumatic stress disorder.[24] Furthermore, the leading cause of direct maternal deaths occurring within a year after the end of pregnancy is suicide.[25] In Ireland, prevalence rates of postnatal depression are reported to range up to 28.6 per cent.[26] Poor maternal mental health can negatively affect the mother-infant relationship and infants' neurodevelopment, as well as the wider family.[27, 28] The elimination of degrading treatment and loss of dignity and control in childbirth is clearly critical.

2.8 The demand for choice

Two decades ago, in 1996, the WHO affirmed midwives as the most appropriate, and cost-effective caregivers in normal pregnancy and birth[29], yet, Ireland significantly lags behind other countries in terms of choice in maternity care. All reports over recent decades on consumer views of maternity care in Ireland have consistently shown high levels of dissatisfaction with a system of care at odds with the needs of the healthy majority. Despite persistent demands for choice of midwifery models of care, the AIMS Ireland 'What Matters to You' survey showed 5.5 per cent of respondents had access to midwifery-led care. Furthermore, 91.7 per cent shared the view that women in general should have the choice of a freestanding birth centre, and 58.5 per cent said that they would personally choose a free standing birth centre if the service were available.[30]

Birth Centres have expanded globally since the 90s in response to their established benefits for healthy women and their babies, and cost-effectiveness, compared to obstetric units. In 2011, the Birthplace in England Research Programme[31] published a ground-breaking report on the outcomes of maternity care across the country for 'low risk' healthy women. Commonly known as the Birthplace Study, outcomes across four maternity care settings were compared: the home, 'free-standing' Birth Centres, 'along-side' midwifery-led units (MLUs) integrated with maternity hospital services, and obstetric units.

The findings with respect to Birth Centres showed that for all women – including women having their first baby – no differences were found in perinatal outcomes compared to obstetric units. The odds of having Caesarean or instrumental birth, or surgical incision of the birth canal (episiotomy) were "*significantly and substantially*" reduced for women who planned birth in Birth Centres compared to obstetric units. Increased levels of satisfaction for women and increased job satisfaction for midwives was also associated with Birth Centres. The probability of transfer to an obstetric unit during labour or immediately after birth was reduced in Birth Centres compared to the home or MLUs, a finding consistent for both first-time mothers and those having their second or subsequent baby. On economic analysis, Birth Centres led to significant cost savings for the NHS

when compared to obstetric units. Representing the most reliable evidence to date on birth place outcomes, the Birthplace Study provides compelling evidence on safety, reduced intervention including CS, increased satisfaction and cost savings – all of which supports women's demands in Ireland for choice in childbirth. Yet, the recently published National Maternity Strategy 2016-2026[32] stipulates, without justification, that no Birth Centres are to be developed in Ireland. This demonstrates the direct impact by the Eighth Amendment on the demand for choice, which ensures that women's decision-making is not a primary factor in establishing her range of choices in pregnancy and childbirth.

2.9 Private profits

Obstetrics can be a lucrative business, as the Irish experience demonstrates. Public and private obstetric care operates side by side on the same site. The market for private maternity care is substantial, and private obstetric fees is additional to their state salaries. Private medical care is heavily subsidised by the state, and obstetricians have unlimited access to the full range of public hospital facilities, including midwifery time, without charge, for their private patients. Given these circumstances, obstetric economic self-interests is a key factor in the lack of provision for choice in childbirth, supported and promoted by the Eighth Amendment in its constitutional enshrinement of a status quo where women's decision-making is not given due weight or consideration.

3. THE EIGHTH AMENDMENT

A recent decision of the UK Supreme Court in Montgomery v Lanarkshire Health Board (2015)[33], addressed in more detail below, the judge writes: "*Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being*". In Ireland, because of the Eighth Amendment, those days are very much with us, evidenced by the extreme incursions into the personal and reproductive autonomy and sense of security suffered by respondents to the AIMSI survey.

3.1 The law on overruling pregnant women's choices

When a pregnant woman in Ireland makes an informed refusal to treatment recommended by her medical team, and there are perceived implications for the 'life or health' of her unborn baby, the National Maternity Strategy[32] and the National Consent Policy[1] state that, under the Eighth Amendment, legal advice should be sought.

As a result of this policy, the High Court has been asked to intervene in a number of cases in which women have made medical decisions in late pregnancy which, their doctors argued, placed their unborn baby's life or health at risk. The cases of PP v. HSE[34] and Miss Y[35] suggest that where the risk to an unborn baby's life approaches certainty, even in relatively early pregnancy, highly invasive treatment may be used to preserve that life. The Supreme Court has held that the Eighth Amendment means that, in these cases, none of the mother's constitutional rights or interests,

besides her own right to life, can be weighed in the balance in assessing whether invasive treatment is justified. The position is less clear, but potentially equally troubling, where the risk to the unborn baby's life or health is less certain.

In HSE v. B[36] the High Court recently outlined the applicable legal principles:

(i) Autonomy: A pregnant woman is exercising her constitutionally-protected parental autonomy when she makes a medical decision which may affect the health or life of her unborn child. As such, the State can only intervene to protect the unborn in exceptional circumstances. A remote risk to the unborn baby's life or health will not justify intervention.

(ii) Proportionality: The Court will take account of the type of intervention required to reduce or remove the risk to the unborn's life or health, and weigh it against the likely effect on the woman. The HSE sought an order compelling Ms. B to undergo a Caesarean section, and allowing them to use 'reasonable or proportionate force and/or restraint' to ensure that she could not refuse. Subjecting a woman to invasive surgery is a serious infringement of her human rights. The Court noted that the Eighth Amendment only requires the State "as far as practicable" to defend the right to life of the unborn, and found that a Caesarean section was a disproportionate intervention given that the risk to the unborn in this case was very low. It was therefore an impracticable step.

HSE v. B[36] makes clear that women cannot be compelled to accept medical treatment in their unborn baby's interest where (i) the risks to the unborn from refusal are low and (ii) the proposed treatment is very invasive. However, it does not clarify precisely when women can be compelled to accept treatment short of surgery, or exactly how high the risk to the baby must be before serious unwanted medical, or other state interventions can be justified. This lack of clarity generates serious difficulties for women in negotiating their maternity care.

3.2 Uncertainty and coercion

The Eighth Amendment is inherently ambiguous in its meaning and scope and the Courts have not been able to fully clarify its content. In the context of abortion provision, medical practitioners' inability to confidently interpret the constitution has had damaging consequences for women's human rights. As already shown, the undue uncertainty surrounding the Eighth Amendment's application to refusal of medical treatment in childbirth also has damaging consequences for women's human rights in childbirth.

In Ternovsky v. Hungary,[37] the European Court of Human Rights noted that '*the right to choice in matters of child delivery includes the legal certainty that the choice is lawful and [that women or health professionals are] not subject to sanctions, directly or indirectly*.' Every pregnant woman is entitled to '*a legal and institutional environment that enables her choice, except where other rights render necessary the restriction thereof*.' That environment is not present in Ireland due to the Eighth Amendment.

While the National Maternity Strategy[32] emphasises the importance of communication with the refusing woman, this is not borne out by our experience. Women have been threatened with court

order as soon as they express a desire to refuse treatment These experiences show that the inherent ambiguity of the Eighth Amendment has generated sets of 'working interpretations' built on the assumption that the duty to protect unborn life justifies expansive pre-emptive control of women's birthing choices. Whether or not these 'working interpretations' are well-intentioned by the individuals involved, they contribute to a culture of coercion around childbirth in Ireland within which:

- women's capacity to plan childbirth in an informed way is undermined
- arbitrary violations of women's rights to private life and bodily integrity are normalised
- the family life which women share with their partners, other children and new baby is badly disrupted.

As already noted, it is not clear whether the Courts would support these 'working interpretations' of the Eighth Amendment. In our experience, however, they go unchallenged in practice because rather than contest them, women in the vulnerable position of pregnancy or labour understandably submit under pressure. As such, they perceive that the Eighth Amendment is used cynically to punish non-compliance with medical advice, and to justify interventions which instrumentalises them as mere child-bearers.

The gender bias underpinning the use of threats and coercion to enforce medical intervention is not subtle. It is self-evident that a person of sound mind cannot be forced to undergo a medical procedure (such as a kidney transplant). This principle applies even if the procedure would save the life of another person and even if that other person were their child. Pregnant women, however, are expected to sacrifice their health and dignity, and even potentially their lives, in the name of having a healthy baby as defined by others.

4. FOUNDATION IN HUMAN RIGHTS FOR HIGH-QUALITY SAFE MATERNITY CARE

Care providers have a critical role to play in ensuring that women emerge from childbirth physically and psychologically healthy and are able to develop a responsive and nurturing relationships with their children. The foregoing evidence of the spiral of intervention with its monitoring-pain-epidural-CS dynamic that generates and perpetuates a culture of disrespect, bullying and coercion of pregnant and birthing women shows an impact of the Eighth Amendment which is far removed from protecting the health and life of the unborn for the vast majority of women who choose to continue their pregnancy. Rather, it serves the needs of the institution and medical profession over the interests of women in giving birth safely, effectively achieved by denying their right to refuse medical intervention. It is imperative that the Eight Amendment be repealed, not only for health and safety in abortion but for the health and safety of all pregnant women and their babies.

The assessment of high quality, safe maternity care goes beyond measures of morbidity and mortality to encompass the quality of interpersonal aspects of care received by women seeking maternity services. In recognition that childbirth is a particularly vulnerable time for women, the World Health Organisation (WHO) drew global attention in 2014 to women's mistreatment and associated human rights violations during childbirth, and to the imperative to prevent and eliminate disrespect and abuse of women during facility-based childbirth for the best possible outcomes for

the mother and baby.[38] Referring to the phenomenon of disrespect and abuse in childbirth as "*an important public health and human rights issue*", the WHO endorsed the provision and experience of care as equal determinants of safe, high-quality maternity care, making the key point:

> "*Rights-based approaches to organizing and managing health systems can facilitate the provision of respectful, quality care at birth*".

Endorsed by more than 90 international civil society and health professional organizations, including the International Federation of Gynaecology and Obstetrics (FIGO), the International Confederation of Midwives, and professional associations representing paediatricians, the WHO statement affirms:

> "*every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth*."

Approving guidelines for 'Mother-Baby Friendly Birthing Facilities', FIGO reiterated its support for the WHO position by affirming women's "*right to be treated with dignity and respect*" and called for women's protection from "*unnecessary interventions, practices, and procedures that are not evidence-based, and any practices that are not respectful of their culture, bodily integrity, and dignity*."[39] The Lancet also called for a "*shift in perspective*" to assess maternal health services based on "what women need and want in pregnancy and childbirth."[40]

4.1 Obstetric violence

The far-reaching public health implications of human rights violations in childbirth was further highlighted in 2015, as United Nations and regional human rights experts, the rapporteur on the rights of women of the Inter-American Commission on Human Rights, and the special rapporteurs on the rights of women and human rights defenders of the African Commission on Human and Peoples' Rights issued a joint statement explicitly calling on states to address "*acts of obstetric and institutional violence*".[41]

Latin America, where many countries have relatively newer human rights-based constitutions and bodies of law, has taken the lead in creating legal structures addressing the issue. Venezuela was one of the first jurisdictions to create a statutory right of action recognizing obstetric violence as a form of gender-based violence.[42] The law in Venezuela defines obstetric violence as:

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

A number of examples are provided, including inattention to obstetric emergencies, birth in the lithotomy (legs strapped in stirrups) position, needless separation of mother and child, and augmentation of labour or caesarean delivery without consent.

Argentina and ten Mexican states also recognize obstetric violence as a form of violence against women; the states of Chiapas, Guerrero, and Veracruz even impose criminal penalties on offenders. These laws provide a range of remedies, including administrative complaints, specialized medical arbitration, and complaints before federal and state human rights commissions.

In the UK, the NHS is also increasingly using a human rights based approach not only to improve patient experience but as means to ensure patient safety. In response to a cluster of maternal deaths at Queen's Hospital Romford in 2011, blamed in part on poor culture and disrespectful behaviour amongst staff, mandatory training on human rights was introduced for all maternity care providers. The outcomes achieved included a measurable impact on the quality of care, reduced complaints, improved communication and staff behaviour.[43]

5. INFORMED DECISION-MAKING AND CHOICE

Creating the foundation for a woman-centred maternity service that is truly fit for purpose, the human rights principles of dignity, autonomy and self-determination reinstate the woman as the central agent in her maternity care. These values are most powerfully articulated in the imperative to treat a person as an end in their own right and not a means to an end. The relevance of this is particularly clear in maternity care where a woman risks being viewed as a means for the creation of life rather than as a person worthy of respect in herself.

Respect for a woman's basic human right to dignity and self-determination is predicted on respect for her autonomous informed decision-making, choices, feelings and preferences about all aspects of her care and treatment in childbirth, including how, where and with whom she gives birth. It means that caregivers who protect women's dignity treat them as capable of making their own decisions about their child's birth, and respect their perception of what it means for them to thrive as human beings. Such caregivers respect women's right to freedom from inhumane and degrading treatment, their right to informed consent and refusal, and their right to non-discrimination.

Caregivers who listen to women, who provide them with comprehensive and accurate evidence-based information, and who respect their choices make a fundamental contribution to a safe maternity service. As the investigations into Ireland's failing maternity services in Galway, Portlaoise, and Drogheda have repeatedly shown, lack of respect for women's dignity has gone hand in hand with clinical and systemic failings that have compromised the safety of mothers and babies.

The UK Supreme Court in Montgomery v Lanarkshire Health Board (2015)[33] shows the interdependence of safety and respect for human rights in maternity care. Mrs Montgomery's doctor treated her with condescension and withheld important information about the risks of vaginal birth for diabetic mothers. As a consequence, her right to make a safe and fully informed choice was denied to her and her baby was damaged during birth. The Court held that a woman '*is entitled to take into account her own values, her own assessment of the comparative merits of*' a proposed course of action in childbirth. She is entitled to decide that it is acceptable to take certain risks with her health and that of her child, even if her doctor considers them unacceptable. Accordingly, the Court found that clinicians must adopt a woman-centred approach to advice-giving during pregnancy and childbirth. 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*".

6. CONCLUSION

Irish society rightfully attaches a high value to motherhood and recognises the intense vulnerability of women during this time. Any interpersonal care that is disrespectful and abusive in nature to women before, during, and after birth is an infringement of a woman's inviolable right to respect, dignity and choice that extends from a human rights framework. All childbearing women need and deserve respectful care and protection of their autonomy and right to self-determination; this includes special care to protect the mother - baby pair as well as marginalized or highly vulnerable women such as adolescents, ethnic minorities, and women living with physical or mental disabilities. Most importantly, as the respondents to the AIMSI survey bear out, disrespectful care is an infringement of women's human rights to non-discrimination, liberty and security of the person, reproductive health and autonomy, and freedom from cruel, inhuman, and degrading treatment. Vindicating these rights means that women cannot be subjected to medical treatment without their full, free and informed consent. It also means respecting competent pregnant women's medical decisions, even where they conflict with medical advice.

Any forced intervention or treatment on a pregnant woman who has made an informed decision that the associated risks outweigh the benefits for her and her baby is an intolerable act. But forced intervention that takes place in a setting where women hold less power than doctors, in a society where women's capacity for pregnancy has been historically used to sanction their exclusion from full citizenship, is more than a simple battery. It is a form of gender-based violence, increasingly recognized around the world as obstetric violence.

The articulation of obstetric violence in legislation – specifically within the ambit of women's human rights to health, equality, and freedom from violence – shows an understanding of the causes and consequences of abuses in childbirth that far exceeds that in Ireland to date. The work of eliminating gender-based violence in Irish maternity care must include legal frameworks that invoke state and institutional responsibility for ensuring respectful care in birth. Repeal of the 8th Amendment is a necessary and critical first step to enable that work to begin. Article 40.3.3. must be removed completely from the Constitution in order to respect the lives, health and choices of pregnant, and there must be no replacement since any restriction will render the current position unchanged for women in continued pregnancy.

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