



**Födelsehuset**

**NGO information to the United Nations  
Committee on the elimination of  
discrimination against Women.**

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**For consideration when compiling the List of Issues with regard to the  
Combined Eighth and Ninth Periodic Report of Sweden under the  
Convention on the elimination of All Forms of Discrimination against  
Women.**

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Födelsehuset/The Birth House  
Haga Kyrkogata 26  
411 23 Göteborg  
Sweden  
+46 31 25 34 07  
mail: [info@fodelsehuset.se](mailto:info@fodelsehuset.se)  
[www.fodelsehuset.se](http://www.fodelsehuset.se)

# Submission of Report to CEDAW on Sweden for Failing to Protect Women's Choice of Circumstance in Birth

*This report highlights concerns regarding Sweden's compliance with its obligations under Article 12 concerning health.*

Födelsehuset, "The Birth House", an NGO in association with HRIC, Human Rights in Childbirth, concerned with rights and choices for women and families around pregnancy and childbirth, want, on behalf of its members and users, together with a fast growing number of invested parents, from various birth activists' groups, to report on the Swedish Government for failing to remove legislative obstructions for women's fundamental human right to choose the circumstances in birth. Further we consider the Government's failure to provide options for out of hospital birth, despite these options' proven superior safety, reflective of a misogyny, by which women's immediate and long time health is not given a high priority.

## Introduction to the problem

According to all international research on *Place of Birth*, (NICE Guidelines 2014, Hodnett et al 2012, Hodnett et al 2013, Birth Place Study 2011, Olsen & Clausen 2012) healthy women with uncomplicated pregnancies who give birth in high risk obstetric units have a significantly higher risk of getting unnecessary interventions in birth, compared to healthy women who give birth out of hospital - either in midwifery-led units or at home with a midwife. Kindly see appendix 1. These birth interventions have no benefit for the baby but in many instances have lifelong sequelae for a woman's mental and physical health, thus making midwifery-led out of hospital birth, the safer choice for healthy women.

## High Intervention Rates is a Consequence of Lack of Quality Midwifery Care in Birth

Although midwives DO attend normal birth in Sweden, they do so in high-risk hospital units, where they refer pregnant and birthing women to a doctor only if complications arise. International recommendations on the benefit of midwifery led care in normal birth are hereby largely perceived as being met. However, the definition of *normal birth*<sup>1</sup> is controversial and differs essentially between the medical profession and the midwifery profession. Despite midwives' attendance at birth, the midwife's professional scope is limited by local doctor-written guidelines, which prescribe various, not necessarily evidence based, interventions, contingent upon narrow medically defined interpretations of what constitutes abnormalities in birth. This is one of the reasons the organization of healthy women's births in high-risk units inadvertently increases the rate of interventions.

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<sup>1</sup> International Confederation of Midwives, ICM:s, definition: "A unique dynamic process in which fetal and maternal physiologies and psychosocial contexts, where the woman commences, continues and completes labor with the infant being born spontaneously at term, in the vertex position without any surgical, medical or pharmaceutical intervention.



Another such reason is the lack of *one to one care*<sup>2</sup> in high-risk labor wards. It is very well documented (Hodnett et al, 2012) that continuous presence of a midwife during a woman's active labor is *the* most significant factor in terms of diminishing interventions and in terms of ensuring an overall good birthing outcome psychologically and physically. The widely disseminated DRG<sup>3</sup> reimbursement system in place, by which labor wards receive money per complication or per intervention according to a specific code, inadvertently hampers normal birth by being overly rewarding of interventions instead of rewarding the *one to one* ratio of midwifery care required to keep birth uncomplicated. *Normal birth*, which requires more presence of a midwife, decreases the labor wards' income from interventions and figures merely as an expense because salaries are taken from another budget.

**In summation: When "Midwifery Care" is organized and regulated by doctors around a medical risk aversion paradigm rather than around professional midwifery's own salutogenic<sup>4</sup> "watchful waiting" paradigm, the benefit of midwifery care is lost.**

### Violations of Women's Right to Consent in Childbirth

The concept of *woman-centered care*, is all but unheard of, and informed choice and consent to treatment, concepts that entered the law only in January 2015, have not yet been assimilated into the paternalistic medical culture, which pervades obstetrics. Consequently most doctors and midwives fear non-compliance with various local doctor-written directives more than they fear violating the women's right to informed consent to treatment or to routine interventions. This results in growing dissatisfaction with the tax financed labor options and an unmet desire to have more choices in pregnancy and birth.

### Financial and Legislative Obstructions for Right to Choose Circumstances of Birth

The lack of financing constitutes a systematic obstruction of women's right to give birth at home. Swedish women who don't want an intervention prone hospital birth (often second time around), and who pay for everyone else's hospital births through their high taxes, cannot get financing for their own birth if they choose to birth outside of a hospital. Because there are no publicly financed alternatives to hospital birth, all midwives are forced to make a living in the hospitals, thereby making unavailable the presence of a skilled midwife for a home birth should you be wealthy enough to afford one. This has increased the number of women who choose to give birth at home - UNASSISTED BY MIDWIVES!!!

Midwives' lack of rights to prescribe necessary emergency medicines to use for out of hospital births in case of post partum bleeding is another such systematic obstruction. This in spite of the fact that Swedish

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<sup>2</sup> 1:1 midwife care: a woman in established labor receives care from a designated midwife for the whole of that labor, or the midwife's whole shift, whichever is the shorter. This midwife will be available to care for the woman 100% of the time. At the end of the shift, care is handed over to another designated midwife who continues 1:1 care of that woman.

<sup>3</sup> Diagnosis-related group (DRG), is a system to classify hospital cases into one of originally 467 groups, a way to identify the "products" that a hospital provides, e.g. an appendectomy, and then gets paid for.

<sup>4</sup> Salutogenesis describes an approach focusing on factors that support human health and well-being, rather than on factors that cause disease.



midwives have wider prescription rights than midwives in any other country, a prescription right that includes strong hormonal contraceptives and morning after-pill.

The lack of financing and the lack in prescription rights function as well contemplated obstructions of midwives' and women's autonomy in that many women and midwives, who would otherwise consider birthing or caring for birthing women at home are prevented either by economic limitations or by an intentional limitation of home birth's otherwise well documented superior safety, both of which limitations are in fact nullifying their formal rights to out of hospital birth.

### **Making Women's Choices Safe.**

Swedish legislation insist on all midwives' obligation to perform abortions, without any exemption on religious or other grounds, because it ensures that safe abortions are free and available as a vital part of women's reproductive freedom. The abortion legislation reflects acknowledgement of women's right to choose IF and WHEN and WITH WHOM to have children. But WHERE and HOW and WITH WHOM to give birth is an equally important part of women's freedom to choose. The consequences of not having access to a skilled midwife for home birth are the same as of not having access to qualified personnel for abortion. It makes both abortions and home births unsafe.

Being a midwife is not a hobby. Midwives know they must serve every aspect of women's choice - be it abortion or home birth.

.....As should Sweden's feminist government.

### **Recommendations to the Swedish Government for Securing Women's Choice of Circumstances in birth**

*With the purpose of ensuring women's right to choose the circumstances of birth, and improving overall maternal health, we suggest that the Swedish Government take the following legislative measures to strengthen midwives and consequently strengthen women's autonomy in birth:*

1. The Government must legislate for free access to a skilled midwife as part of the Tax funded Public Maternity Services.
2. To ensure women's right to choose out of hospital *safe* midwifery care, midwives' prescription rights *must* be expanded to include emergency medicines in case of bleeding and local analgesics for suturing of minor birth tears.
3. To ensure the safety of the baby midwives' authorization must be expanded to include thorough



examination of the newborn baby, which can currently only be performed by pediatricians in hospital, thus constituting yet another obstruction for out of hospital birth.

4. To ensure safe transfer of care, procedures for midwives collaboration with hospitals must be legislated for, both with regards to routine examinations and in the case of complications arising during pregnancy and birth.

5. To limit dangerous birth interventions, legislation must ensure equal representation of midwives on all levels governing birth. In regional councils and in the managements of high-risk labor wards, midwives must partake in determining core principles for care and in the writing of guidelines governing normal birth, thus maximizing the protective benefit of midwifery care, even for women giving birth in hospitals.

6. To adopt the principle of one to one care, thereby reducing unnecessary interventions, the labor wards' reimbursement system must be modified to reflect the higher value of physiological unintervened birth. By putting economic incentives in place which reward Midwifery's core principle of one to one care; better staffing ratios will be prioritized even in hospitals thus helping outbalance the current heavy economic incentives to intervene in birth.

7. To ensure that birthing women's right to informed consent is better respected, The Swedish Government should legislate to encourage a system of periodic oversights of patient files, with specific attention to documentation of information given to the woman.

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Thank you for your attention to these written submissions. If you would like any further information, please contact Födelsehusets/The Birth House's chairperson:

Eva-Maria Wassberg, [eva-maria.wassberg@fodelsehuset.se](mailto:eva-maria.wassberg@fodelsehuset.se), +46 31 25 34 07



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Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: <i>low risk nulliparous women</i>	Number of incidences per 1000 nulliparous women giving birth			
	Home	Freestanding midwifery unit	Alongside midwifery unit	Obstetric Unit
Spontaneous vaginal birth	794*	813	765	688*
Transfer to an obstetric unit	450*	363	402	10**
Regional analgesia(epidural and/or spinal)	218*	200	240	349*
Episiotomy	165*	165	216	242
Caesarean Birth	80*	69	76	121*
Instrumental birth (forceps or ventouse)	126*	118	159	191*
Blood transfusion	12	8	11	16
** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.				
*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.				

Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: <i>low risk multiparous women</i>	Number of incidences per 1000 multiparous women giving birth			
	Home	Freestanding midwifery unit	Alongside midwifery unit	Obstetric Unit
Spontaneous Vaginal birth	984	980	967	927*
Transfer to an obstetric unit	115*	94	125	10**
Regional analgesia(epidural and/or spinal) ***	28*	40	60	121*
Episiotomy	15*	23	35	56*
Caesarean birth	7*	8	10	35*
Instrumental birth (forceps or ventouse)	9*	12	23	38*
Blood Transfusion	4	4	5	8
** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.				
*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.				

<http://www.nice.org.uk/guidance/cg190/chapter/1-recommendations#place-of-birth>