



Midwives for Choice

**Submission to the United Nations Committee Against Torture (CAT) for Ireland's
Second Periodic Examination under the Convention Against Torture and Other Cruel,
Inhuman or Degrading Treatment or Punishment**

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Introduction

1. This submission outlines a system of maternity care in Ireland that violates the rights of women and girls on a daily basis by non-consensual medical intervention in pregnancy and childbirth, and why the Irish Government's failure to protect women and girls, and to vindicate their rights, constitutes a violation of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('the Convention'). This is a gender-specific form of abuse and mistreatment because it exclusively impinges upon the health and rights of women and girls, including the right to refuse medical care and treatment.

2. Midwives for Choice is a voluntary midwifery-led organisation founded in January 2016 to promote the sexual, reproductive and maternal rights of women and girls¹ in Ireland. In the absence of State funding, our members, comprising in excess of 50 to date who are spread across the island, including Northern Ireland, give their time freely to promote the highest attainable level of health by women and girls before, during and after childbirth.

Ireland's legal and policy framework governing rights in pregnancy and childbirth

3. Governing Ireland's ban on abortion introduced in 1983, the language of Article 40.3.3 of the Irish Constitution (the Eighth Amendment), which refers to the 'life' of 'the unborn', has been interpreted to bring the duration of pregnancy, including labour and birth, within the Amendment's reach,² impinging on the fundamental human rights of every pregnant woman and girl to:

- i. bodily integrity and freedom from inhuman and degrading treatment;³
- ii. private life;⁴
- iii. family life, including the right to parental autonomy;⁵
- iv. healthcare information;⁶

¹ While we use the term 'woman/women/girls' we do so in recognition of the nuances and right to people's unique sexual and gender identities and expressions.

² See discussion in the Supreme Court in *Roche v. Roche* [2009] IESC 82.

³ *V.K. v. Slovakia* ECHR, November 8, 2011; *N.B. v. Slovakia* ECHR 12 June 2012; *I.G v. M.K. and R.H. v. Slovakia* [2012] ECHR 1910; *R.R. v. Poland* [2011] ECHR 828. See further Juan Méndez, UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/22/53 (2013), 10-11 and Center for Reproductive Rights, *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis* (2011).

⁴ See e.g. *Y.F. v. Turkey* ECHR 22 July 2003, *Juhnke v. Turkey* ([2008] ECHR 379; *Yilmaz v. Turkey* ECHR 1 February 2011, *G.B. and R.B. v. Republic of Moldova* ECHR 18 December 2012 ; *Csoma v. Romania* ECHR 15 January 2013 and *Konovalova v. Russia* ECHR 8 March 2016 (lack of informed consent)

⁵ *Ternovsky v. Hungary* ECHR 14 December 2010, the notion of a right to become a parent involves some measure of freedom as it its exercise; cf *Dubaska* ECHR 15 November 2016.

⁶ See e.g. *R. R. v. Poland* [2011] ECHR 828 (delays in accessing ante-natal testing which would have enabled woman to make an informed decision about her pregnancy, and which exacerbated the

v. freedom from discrimination.⁷

4. Vindicating these rights⁸ means that women and girls cannot be subjected to medical treatment without their full, free and informed consent. It also means respecting competent pregnant women's informed decisions and choices, even where they conflict with medical advice.⁹ Recently, in *Montgomery v. Lanarkshire Health Board*,¹⁰ the UK Supreme Court held that a pregnant 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. In that judgment, Lady Hale 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, in part because of the Eighth Amendment, those days are very much with us.

5. When a pregnant woman in Ireland makes an informed refusal of treatment recommended by her medical team, and there are 'implications for the life or health¹¹ of the baby', the Health Service Executive (HSE) National Consent Policy¹² states that, under the Eighth Amendment, legal advice should be sought: "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."

6. Citing the Eighth Amendment and the National Consent Policy, the HSE National Maternity Strategy 2016-2026¹³ notes the restriction on women's rights to autonomous decision-making "where there are implications for the health or life of the baby, as defined by her team of health care professionals." The Strategy reiterates that the right to informed choice about medical care and treatment in pregnancy and childbirth is respected "insofar as it is safe to do so", applying the same

plaintiff's existing vulnerability), *Tysiac v. Poland* [2007] ECHR 212 (lack of adequate information), *AS v. Hungary* CEDAW/C/36/D/4/2004 (lack of adequate information)

⁷ *Alyne da Silva Pimentel Teixeira (deceased) v Brazil*, CEDAW, UN Doc CEDAW/C/49/D/17/2008 (2011)

⁸ Some countries, such as Argentina (2009), Venezuela (2007) and Mexico (2014), prohibit or even criminalise breaches of these rights, using new laws against 'obstetric violence'. 'Obstetric violence' refers to abusive, dehumanizing or violent obstetric care. It can include unnecessary or non-consensual treatment; coercing treatment by over-emphasising maternal or foetal risk; silencing women's dissent using social authority; lying to women in the course of childbirth in an effort to coerce treatment; forcing intervention in labour; enforcing control over a pregnant woman's body including by use of restraints or sedation.

⁹ For example, in the UK the courts will not entertain an application to overrule a woman's refusal of C-section unless her mental capacity is in issue. See e.g. *St George's Healthcare NHS Trust v. S* [1998] 3 All ER 673; *Re MB* [1997] 38 BMLR 175 CA.

¹⁰ [2015] UKSC 11

¹¹ In *IRM v Minister for Justice* [2016] IEHC 478, Humphreys J. suggests that the unborn has a wide range of constitutional rights, pre-dating the 8th Amendment and including the right to health. There is conflicting authority at High Court level (see especially *Ugbelese v. MJELR* [2009] IEHC 598), and this judgment is under appeal.

¹² National Consent Advisory Group (2014). 'National Consent Policy'. Health Service Executive (Revised May 2016)

¹³ Department of Health (2016). Creating a Better Future Together: National Maternity Strategy 2016-2026.

principle to choice on place of birth: “A choice of birth setting will be facilitated where it is safe to do so”.

7. As such, pregnant women are the only group of mental competence whose rights are systematically undermined in the institutional health care setting in Ireland. As a result of these policies, the High Court has been asked to intervene in several cases in which women have made medical decisions in late pregnancy which, their doctors argued, placed their foetus’ life or health at risk.¹⁴ The cases of *PP v. HSE*¹⁵ and *Miss Y*¹⁶ suggest that where the risk to an unborn child’s life approaches certainty, even in relatively early pregnancy, highly invasive treatment may be used to preserve that life. The Supreme Court has held¹⁷ 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 child’s life or health is less certain. In *HSE v. B*¹⁸ the High Court recently outlined the applicable legal principles:

- **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 child in exceptional circumstances. A remote risk to the unborn baby’s life or health will not justify intervention.
- **Proportionality:** The court will take account of the type of intervention required to reduce or remove the risk to the child’s life or health, and weigh it against the likely effect on the woman. In *HSE v. B*, 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. In *HSE v B*, the court found that a Caesarean section was a disproportionate intervention given that the risk to the baby in this case was very low. It was therefore an impracticable step.

8. *HSE v. B* makes clear that women cannot be compelled to accept medical treatment in their unborn child’s interest where (i) the risks to the baby 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

¹⁴ These judgments are unreported. They include *South Western Health Board v K and Anor* [2002] I.E.H.C 104; *Health Service Executive v F*, (High Court, *ex tempore*, Birmingham J., November 20, 2010. See also *Mother A v. Waterford Regional Hospital*, Hedigan J., March 11 2013 in which Hedigan J. was not required to make an order because the woman decided to have a C-section.

¹⁵ [2014] IEHC 622; the 8th did not require subsection of a woman’s body to somatic care after brain-death in order to preserve her pregnancy where the foetus could not be born alive. The court suggests that where the foetus is viable, more extensive treatment may be justified.

¹⁶ Ms. Y unsuccessfully sought life-saving abortion under the Protection of Life During Pregnancy Act, 2013. Ms. Y was pregnant and suicidal and, arguably, accordingly there was a risk to the foetus’ life. The Act contemplates that abortion may only be provided where it is the ‘only’ means of addressing the threat to the pregnant woman’s life. The High Court granted orders for Ms. Y’s forcible feeding and hydration, and for a compulsory Caesarean section.

¹⁷ [1992] IESC 1

¹⁸ [2016] No. 8730P

medical, or other state interventions, can be justified.¹⁹ This lack of clarity generates serious difficulties for women and practising midwives.

The Eighth Amendment, Uncertainty and Coercion

9. 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.²⁰ An analogous point might be made about the undue uncertainty surrounding the Eighth Amendment's application to refusal of medical treatment in childbirth. In *Ternovsky v. Hungary* 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.'²¹ That environment is not present in Ireland.

10. Non-consensual intervention is long recognised by women as part and parcel of Ireland's maternity care. A national study commissioned by the Department of Health in the 1980s showed conclusively that non-consensual medical intervention was a significant problem in the labour ward.²² More recently, the Association of Maternity Services Ireland (AIMSI) has shown the continued failure to respect women's fundamental rights in labour and birth. Reports of coercion, commonly made by women to AIMSI, include threats of arrest by the Gardaí to compel compliance with medical instruction, particularly in relation to induction of labour.²³ In the most recent survey conducted by the association in 2014 in which 2,836 women who had given birth in Ireland between 2010-2014 participated, 50 per cent reported being denied the opportunity to refuse a test, procedure or treatment during labour.²⁴ Similar rates were found by its last survey in 2008 when 75 per cent of respondents believed consent was an issue of concern in Irish maternity care.²⁵ The most commonly reported procedures to which women were subjected without their consent were membrane 'sweeps'; artificial rupture of membranes; the use of oxytocin; and episiotomy.²⁶

11. We are also aware of the withdrawal of services by the HSE from a woman actively labouring in the home who refused to transfer to hospital for antibiotic treatment, abandoning the mother and baby to the risks of unattended birth. In a similar home birth case, the HSE succeeded in coercing a full-term pregnant woman to transfer for antibiotic treatment under threat of court order to have her baby taken into State custody at birth, notwithstanding that there was no evidence of abuse or neglect in the

¹⁹ By contrast, in the UK a pregnant woman is permitted to refuse medical treatment even where the intervention is minor; *Re MB (An Adult: Medical Treatment)* (1997) 2 FCR 541

²⁰ *A, B and C v. Ireland* [2010] ECHR 2032. See similarly *P. and S. v. Poland* [2012] ECHR 1853

²¹ *Ternovsky v. Hungary* ECHR 14 December 2010

²² O'Connor, M. (1995) *Birth Tides*. Pandora Press.

²³ Association for Improvements in the Maternity Services Ireland: 'Submission to the Citizens' Assembly on the Eighth Amendment of the Constitution', 15 December 2016; Available at: <http://aimsireland.ie/the-aims-ireland-submission-to-the-citizens-assembly/>, pg.15

²⁴ Association for Improvements in Maternity Services in Ireland (AIMS Ireland) March 2014. 'What Matters To You Survey 2014'. Available at: <http://aimsireland.ie/what-matters-to-you-survey-2015/womens-experiences-of-consent-in-the-irish-maternity-services/>

²⁵ *Ibid* (see note 23), pg.16

²⁶ *Ibid* (see note 23), pg.16

home.²⁷ While the National Maternity Strategy emphasises the importance of communication with the refusing woman, this is not borne out by our experience. Women have been threatened with court action almost as soon as they express a desire to refuse treatment.

12. We refer to Appendix 1 which presents the personal testimony of Caoilfhionn, outlining her experience of Ireland’s maternity services on giving birth to her second child after an uneventful pregnancy, as a typical example of the experiences motivating women to reach out to us for support and of the deeply traumatic and enduring negative affect on maternal psychological wellbeing and the mother-infant relationship of mistreatment and abuse of women’s fundamental human rights at a time of extreme vulnerability. The following excerpts from the 2014 AIMS survey²⁸ highlight the coercion and bullying that women experience in pregnancy and childbirth through selective information provision, threats, risk inflation and the language of medical necessity:

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

“I felt angry at my full term appointment; when I said I didn’t want a sweep I was asked if I knew the risks involved in not intervening, stillbirth being one. Risks like infections from unnecessary sweeps weren’t mentioned.”

“I was told I had no choice when it came to my treatment; everything was ‘hospital policy’.”

“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’.”

13. These experiences suggest that the inherent ambiguity of the Eighth 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, they contribute to a culture of coercion around childbirth in Ireland. Within this culture:

- 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;
- 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, vulnerable women in pregnancy and childbirth understandably submit under pressure to unwanted medical intervention.

14. In his report on a visit to Ireland in 2016, the Council of Europe’s Commissioner for Human Rights noted that Ireland’s current legislation seriously hampers women’s access to sexual and

²⁷ In *Hanzelkovi v. Czech Republic* [2014] ECHR 1375 the ECtHR found a violation of the right to private and family life where a baby was taken from its mother immediately after birth, as a precautionary measure to protect his health.

²⁸ *Ibid* (see note 24)

reproductive health and rights. Noting allegations with respect to women in childbirth of a “*common practice by hospitals of invoking the Eighth Amendment - with threat of, or actual, court order - to force women to comply with medical decision-making about their care and treatment with which they do not agree*”,²⁹ the Commissioner urged the government to make progress towards a legislative regime that is more respectful of the human rights of women, including their right to be free from ill-treatment, the right to the highest attainable level of physical and mental health, and the right to private life, adding that he strongly hoped the Eighth Amendment would soon be removed.³⁰

The active management of labour

15. The introduction of the Eighth Amendment in 1983 intensified non-consensual medical intervention in childbirth which by then had become routine under the obstetric regime known as the “active management” of labour. Developed at the National Maternity Hospital in Dublin in the 1960s when hospital labour wards had reached the limits of their capacity in the movement of birth under midwifery care in the home to hospital-based care under medical supervision, active management is a set of obstetric protocols that limit the amount of time women and girls are given in labour in which to have their baby by enforcing turnover of 3 births per labour ward bed in the 24-hour period.³¹

16. Obligated to give birth within 8 hours,³² women and girls are routinely subjected to regular and invasive internal examinations during labour. Using a graph to plot progress in labour against the clock, the cervix (neck of the womb) is checked to ensure dilation at a rate of one centimetre per hour.³³ Amniotomy, used routinely to induce and accelerate labour,³⁴ involves puncturing the protective membrane enclosing the waters surrounding the baby in the womb with an amnihook, an obstetric instrument resembling a crochet needle. In the event that the obligatory rate of labour progress is not maintained, the effect of breaking the waters is intensified by administering an intravenous infusion of Syntocinon,³⁵ a synthetic form of the hormone oxytocin. Used in the induction and acceleration of labour to enforce contractions at a rate of 7 in 15 minutes in first births, or 5 in 15 minutes in subsequent birth³⁶, pharmacological oxytocin forces the womb to contract more frequently and powerfully than nature intended, thereby heightening the woman’s pain.

17. The chain of intervention resulting from these procedures further intensifies the associated pain and suffering. Fetal distress is a danger in active management acknowledged by its architects,³⁷ hence,

²⁹ Council of Europe. ‘Report by Nils Muiznieks, Commissioner for Human Rights of the Council of Europe, following his visit to Ireland from 22 to 25 November 2016’. Strasbourg, 29 March 2017; para 80. Available at: <https://wcd.coe.int/com.instranet.InstraServlet?command=com.instranet.CmdBlobGet&InstranetImage=2968549&SecMode=1&DocId=2399932&Usage=2>

³⁰ Ibid, para 93 and 94.

³¹ O’Driscoll, K., Meagher, D., Robson, M. (2003). *Active Management of Labour*. (4th Edition) Mosby.

³² O’Driscoll, K., Stronge, J.M., Minogue, M. ‘Active Management of Labour’. *British Medical Journal*, 1973, vol.3, pg.135-137

³³ Ibid

³⁴ Ibid

³⁵ Ibid

³⁶ <https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2016/05/31.-Oxytocin-to-Accelerate-or-Induce-Labour.pdf>

³⁷ Ibid (see note 32)

electronic fetal monitoring is mandated in the use of oxytocin until the baby is born.³⁸ Limiting mobility, including the option of using a shower or bath, electronic fetal monitoring deprives women and girls of basic comfort measures to help them cope with the harrowing effects of active management.

18. During the phase of childbirth when the baby's head descends through the birth canal, women and girls are given one hour in which to deliver the baby. Typically in a prone position, they are coached to push against the force of gravity and beyond their body's natural instincts and cues, by holding their breath and pushing to a count of 10, repeated 3 times during each contraction.³⁹ The approach is commonly known to women as "purple pushing",⁴⁰ so-called because it makes their face turn purple due to lack of oxygen from prolonged breath-holding. Should they fail despite these efforts to birth their baby within the allocated hour, an episiotomy (surgical incision) may be performed to expedite delivery by enlarging the vaginal opening. Alternatively, instrumental birth may be employed by use of forceps or vacuum. With a firm focus on early delivery, the active management protocol dictates that Caesarean section be considered after a period of 8 hours from labour onset, and performed no later than 12 hours unless delivery is imminent.⁴¹

19. Intervention in the normal physiological process of childbirth without medical necessity carries risks for the baby. Oxytocin has been identified as a salient factor in infant brain damage⁴² and in intrapartum fetal deaths.⁴³ In 2014, 1 in 5 babies born at the National Maternity Hospital in Dublin where active management originated were admitted to intensive care following birth.⁴⁴ Adding to fears and anguish about the baby's safety, the mother's separation from her baby denies women and girls the unique early bonding experience with their newborn.

20. "Military efficiency, but with a human face" is how its architects, Drs Kieran O'Driscoll, Declan Meagher and Peter Boylan, describe active management.⁴⁵ Based on the doctrine of assumed consent, active management relies on blanket "consent" forms which are still in common use today in Ireland's maternity care. The concept of informed decision-making or choice is excluded from the frame of active management by eliminating the possibility that a woman or girl might choose to refuse these interventions. Characterised by patronising, dehumanising and degrading attitudes toward women in labour, the manual sets out the parameters for bullying and coercing women into compliance:⁴⁶

"The main purpose of antenatal preparation - and should always be seen to be - is to define a woman's role in labour and to teach her how to fulfil it ... An expectant mother owes it to herself, her husband and her child, and to every other woman sharing the facilities of the same delivery unit, to be well briefed on the subject of a mother's contribution to labour. The

³⁸ Ibid (see note 36)

³⁹ Di Franco, J. T., Romano, A. M., & Keen, R. (2007). 'Care Practice #5: Spontaneous Pushing in Upright or Gravity-Neutral Positions'. *The Journal of Perinatal Education*, 16(3), 35-38.
<http://doi.org/10.1624/105812407X217138>

⁴⁰ <http://www.independent.ie/lifestyle/why-purple-pushing-is-often-to-blame-26791754.html>

⁴¹ Ibid (see note 32)

⁴² Taylor R. (1998) In *Quick birth drug can kill babies*, Simon Cooper, *The Observer*, 19 April, 1998

⁴³ Department of Health. (1995) *Confidential Enquiry into Stillbirths and Deaths in Infancy - 1993: Annual Report*, Parts 1 and 2. London: HMSO

⁴⁴ National Maternity Hospital. Annual Report 2014. Available at:
http://www.nmh.ie/_fileupload/Annual%20Reports/FB%20NMH%20AR%202014.pdf

⁴⁵ O'Driscoll, K, Meagher, D, Boylan, P. (1993). *Active Management of Labour*. (3rd Edition) Mosby Year Book Europe Ltd, 1993

⁴⁶ Ibid

disruptive effect of one disorganised and frightened woman in a delivery unit extends far beyond her individual comfort and safety, and there should be no hesitation in telling her so. ... Where necessary, it should be bluntly stated that midwives are not expected to submit themselves to the sometimes outrageous conduct of a perfectly healthy women who cannot be persuaded to cross a narrow corridor from an antenatal clinic to attend classes ... Such women must learn how to behave with dignity and purpose during the most important event of their lives. Nor should midwives be held responsible for the degrading scenes that occasionally result from failure of a woman to fulfil her part of the compact.”⁴⁷

21. According to the latest edition of the active management manual, its original philosophy and principles dating back to the 60s remain equally relevant today.⁴⁸ The active management of women in labour underpins the structure and functioning of maternity care in Ireland. In turn, the structure and functioning of maternity care depends on active management. The manual explains: “...the delivery unit constitutes the bottleneck in a maternity service through which all women must pass. The result is that it is not possible to plan maternity hospital accommodation or to allocate professional staff unless the total number of hours women are in labour can be calculated in advance.”⁴⁹ In this light it is clear that the system of centralised birth under medical control would soon collapse if women’s rights to bodily integrity, self-determination and autonomy were respected in labour and birth. It is little wonder therefore that in this context women perceive that the Eighth Amendment is used cynically to punish non-compliance with active management and to justify its interventions which instrumentalise them as mere child-bearers.

International standards for a rights-based approach to maternity care

22. Ireland’s policy and legal framework governing rights in pregnancy and childbirth diverges significantly from international standards in maternity care. In recognition of a critical human rights issue in the provision and experience of maternity care, guidelines produced jointly in 2015 by the International Federation of Gynaecology and Obstetrics, International Confederation of Midwives, White Ribbon Alliance, International Paediatric Association and the World Health Organization affirmed 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.*”⁵⁰ The Lancet has also called for a “*shift in perspective*” to assess maternal health services based on “*what women need and want in pregnancy and childbirth.*”⁵¹

23. In its concluding observations of Ireland’s periodic review in 2017, CEDAW called for the abandonment of Ireland’s highly medicalised system of maternity care that fails to meet international

⁴⁷ Ibid

⁴⁸ Ibid (see note 31)

⁴⁹ Ibid (see note 31)

⁵⁰ International Federation of Gynaecology and Obstetrics; International Confederation of Midwives; White Ribbon Alliance; International Paediatric Association; World Health Organization. ‘Mother-baby friendly birthing facilities’. *International Journal of Gynecology and Obstetrics*. 128 (2015) 95-99

⁵¹ ⁴ [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60859-X/fulltext?rss%3Dyes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60859-X/fulltext?rss%3Dyes)

human rights standards.⁵² Referring to the “*economic rationalism*” of active management, Swiss human rights expert Ms Patricia Schultz told the government that it “*transformed the most important experience of a lifetime for women and their partners into a production-line process*”.⁵³ Outlining the necessary actions to be taken, CEDAW called for a broadly-based reform of Ireland’s maternity care policy underpinned by an individualised approach including respect for the normal physiological birth process,⁵⁴ backed up by the commitment of resources including appropriate training of service providers, for the development of choice in maternity care at community level.⁵⁵

No regard has been shown so far for the recommendations made by CEDAW. On the contrary, the Government’s steadfast commitment to the centralised, industrial model of maternity care has led in the interim to the investment of €300 million in the first of four ‘state-of-the-art’ new maternity hospitals, representing the biggest maternity hospitals in Europe.⁵⁶ The more maternity services are centralised into larger units, the greater the need for active management to avert a labour ward bottleneck, and the more remote the possibility that informed consent is offered to the individual woman by hospital staff.

Ireland’s breach of the Convention

24. We contend that the obstetric practice of active management of labour in the absence of clinical necessity and without free and informed consent constitutes a gross infringement of the rights of women and girls in childbirth to bodily integrity, dignity and personal autonomy, including the right to be free from gender-based discrimination and violence. As this infringement concerns essential female bodily functions, it bears on manifold aspects of the individual’s personal integrity including physical and mental wellbeing, as well as family life. We assert that Ireland is in violation of Articles 2, 10, 12, 13 and 16 of the Convention for the following reasons:

- i. In contravention of Article 16, the State has acquiesced and continues to acquiesce in the obstetrical practice of active management of labour, in the absence of medical necessity and without free and informed patient consent, that leads to significant physical and mental suffering in childbirth that, in some cases, is continuing, thereby constituting discriminatory gender-based cruel, inhuman and degrading treatment of women and girls;
- ii. In contravention of Article 16, the State has acquiesced and continues to acquiesce in the obstetrical practice of active management of labour, in the absence of medical necessity and

⁵² United Nations. ‘Concluding observations on the combined sixth and seventh periodic reports on Ireland’. CEDAW/C/IRL/CO/6-7. Paras 44 & 45. Available at:

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=1071&Lang=en

⁵³ Midwives for Choice. ‘Ireland’s industrialised system of maternity care criticised by UN’. 6 March 2017. Available at: <http://midwivesforchoice.ie/mfc-press-statement/>

⁵⁴ Ibid (see note 52)

⁵⁵ Midwives for Choice. ‘Ireland slammed for use of ‘active management’ system in labour at UN CEDAW hearing in Geneva’. 16 February 2017. Available at: <http://midwivesforchoice.ie/mfc-press-statement/>

⁵⁶ Canning, P. ‘New maternity hospital will be Europe’s biggest birth factory’. Irish Times, 12 May 2017. Available at: <http://www.irishtimes.com/opinion/new-maternity-hospital-will-be-europe-s-biggest-birth-factory-1.3077908>; ‘The biggest maternity hospital in Europe flies in the face of women’s human rights in childbirth’: <http://midwivesforchoice.ie/mfc-press-statement/>

without free and informed patient consent, for the purpose of averting a hospital labour ward “bottleneck”, contrary to scientific evidence on better outcomes and cost-effectiveness of a midwifery-based model of care at primary care level for the healthy majority, and despite widespread consumer demand;⁵⁷

- iii. In contravention of Article 2, the State has failed and continues to fail to take effective measures to safeguard women and girls in childbirth from the gross interference with their rights to bodily integrity and autonomy which active management constitutes and for which the State is responsible;
- iv. In contravention of Article 10, the State has failed to ensure that the universal human rights of women and girls in pregnancy and childbirth are known and adhered to by all relevant personnel involved in maternity services;
- v. In contravention of Articles 12 and 13, the State has failed to conduct impartial investigation despite individual cases alleging non-consensual treatment in pregnancy and childbirth taken by victims in the courts.

Recommendations for Ireland

25. On the basis of Ireland’s violation of its obligations pursuant to the Convention, we respectfully propose that the Committee make the following recommendations to the Irish State:

1. The State should take all necessary measures to ensure the Eighth Amendment is removed from the Constitution in recognition that it violates the rights of women and girls in pregnancy and childbirth to dignity, autonomy, self-determination and bodily integrity, including the right to respect for private and family life; the right to enjoy the highest attainable level of physical and mental health; the right to freedom from gender-based discrimination and violence; and the right to freedom from cruel, inhuman and degrading treatment.
2. The State should ensure that its laws and policies do not violate the legal, constitutional and human rights of women and girls in pregnancy and childbirth.
3. In accordance with the recommendations of CEDAW, the State should ensure woman-centred maternity care characterised by individualised care and underpinned by respect for the normal birth process;

⁵⁷ Birthplace in England Collaborative Group, Brocklehurst P, et al. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal*. 2011;343. Available at: www.npeu.ox.ac.uk/birthplace

4. As part of its commitment to acceptable maternity services, the State should take steps to ensure that reproductive and maternal rights are known and adhered to by all relevant personnel so as to ensure that all public and private maternity services respect, protect and fulfil the human rights of women and girls in pregnancy and childbirth, with appropriate sanctions put in place and implemented in the event of a breach.

5. As part of its commitment to acceptable maternity care, the State should ensure that all allegations of coerced intervention and treatment in pregnancy and childbirth are impartially investigated and that victims of such practices are granted effective remedies.

Philomena Canning, Chairperson
Midwives for Choice
26 June 2017

Appendix 1. Correspondence to Midwives for Choice from Caoilfhionn in Limerick, May 2017

It was my worst nightmare. I had a trouble-free pregnancy and prepared myself well but despite being very vocal about my desire to have a normal birth, I was forced into induction a week before my due date which ended in emergency C-section as the induction just didn't work. I would have accepted a C-section if I felt it was necessary but I know it wasn't. It's soon coming up on 2 years since the birth of my little boy and I still haven't told most of my friends and extended family that I had a C-section – I just can't verbalise it - I find it all so upsetting and can be in floods of tears listening to reports on the radio/newspaper about C-section rates etc. I think I have only got to a place of wanting to do something now that I can see my little boy is ok. Up to this I just was in a constant state of dread and panic when I thought about it. When my little boy was about 4 months old, he developed baby eczema and I think in a slightly depressed way I was obsessed with the fear that the C-section was responsible. I also had a lot of back/pelvic pain for about 9 months.

I want to make a formal complaint as my consultant was very adversarial when I said I didn't want to be induced. There's a general acceptance of cruel birthing in this county and I feel like taking this further because I think what happened to me is incredibly common (terrorised into an induction) by a consultant (forcibly) giving a (self-serving) opinion and a woman fearfully acquiescing. I felt absolutely trapped - like a cornered animal. I was also terrified at a psychic level that they would take the baby from me as I was told to 'stop being selfish and thinking of myself'. It's so immoral and cruel but happens all the time.

I met a woman recently who had a horrendous birth two years ago that she hadn't recovered from either – she had been induced, then her labour had been slowed down because there was no room in the labour ward, then sped up and slowed down again. The baby went into distress and she had a delivery that has left her with injuries requiring surgery this summer. She didn't know me or that I also had a traumatic birth but she herself was so traumatised and preoccupied by what had happened that she couldn't help talking about it.

I did research and talked to several knowledgeable people and rang the consultant to say I wanted to wait for the baby to be ready, but I was basically threatened with my baby being stillborn. The reasons for induction changed at each conversation – the baby was too big and might need its shoulders broken to get born, then the placenta was getting 'tired', and next my age was a problem ... so there was no 'informed consent'. The consultant never went through the pros and cons; in fact, she said there were no cons to an induction when I specifically asked. I didn't have full information about what was happening, she just lied and said I had to be induced for medical reasons.

In my notes is this 'C-Section Consent' form – I am sure this is pretty standard but I don't recall her discussing any of the pros and cons on the form. I did say 'there must be some other way' and she turned and said 'if we don't do this now, you will end up with a hysterectomy'. It was pretty callous. I was awake for the procedure and I wept throughout the whole operation.

I couldn't face the follow-up appointment until my son was 3 months old – basically because the thought of meeting her made me ill with anxiety. I really felt like the victim of an assault. I spent the first year in horrendous self-blame that I hadn't been stronger or more decisive or just stayed at home, but I've now begun to realise that this whole system is constructed to keep women on this conveyor belt system that damages them. I still grieve for the birth my little boy didn't have and feel an inexplicable sense of shame about what happened – it hurts at a deep soul level. I am more and more accepting but it still can feel horrendous.