Birthrights Submission for the UN Special Rapporteur on Violence Against Women and Girls Country Visit to the UK

Executive Summary

At the heart of different forms of violence against women and birthing people in maternity care is a consistent failure to listen their voices and a complete disregard for their fundamental human rights. There is a failure from Government to the frontline to understand how the UK human rights laws apply to maternity care and the fact that it is obliged to uphold these rights.

This lack of understanding causes breaches that can be seen in coercive or non-consensual practices, lack of qualified information, and service closures, that have disproportionate outcomes for women and birthing people from marginalized communities.

Breaches combine to contribute to community and societal trauma and distrust in the healthcare system. A maternity service that understands and protects human rights during pregnancy and birth is essential to tackle violence and provide safe care.

About Birthrights and Our Source of Information

Birthrights is the leading authority on the human rights of women and birthing people during pregnancy and birth in the UK[1]. We believe that all women and birthing people should be able to exercise their right to make informed decisions about their bodies and care, and to do so free from discrimination, coercion and violence. We champion rights by **supporting women and birthing people, training healthcare professionals (HCPs), holding systems and institutions to account**, and making visible diverse experiences of maternity care.

In this submission we draw on information from

- **Our information and advice service** (in 2023 we had nearly 800 individual enquiries to our advice and information service and each month 15-25% of enquiries relate explicitly to birth trauma)
- **Our training** (in 2023 we trained more than 1,000 healthcare professionals across 25 NHS Trusts on how the law applies to practice)
- **Our report *Systemic Racism, not Broken Bodies*[2]**, based upon a year-long inquiry, led by an expert panel, which included a survey of more than 1,000
- **Our website, social media and networks** (in 2023, our website had 246,000 unique visitors and our factsheets attracted 71,473 unique visitors.)

Legal, Institutional and Policy Frameworks

[1] Birthrights - your human rights during pregnancy and maternity
[2] Inquiry into racial injustice in maternity care - Birthrights

Each month 20-35% of enquiries we receive to our advice and information service relate explicitly to complaints regarding birth trauma that derives from **physical and emotional violence**. This is only the tip of the iceberg and given the scale of the issues that are experienced in maternity care is sadly unsurprising.

Inquiries[2] into maternity failings at NHS Trusts and quantitative data[3] demonstrate that women and birthing people face different types of violence and too often they are ignored or dismissed by HCPs. Our Inquiry found poor outcomes for Black and Brown women and birthing people are the result of systemic racism, not broken bodies.

Despite the fundamental rights enshrined in law, women and birthing people are frequently **denied agency and their bodily autonomy is not respected.** We know that violence against women during childbirth is "part of a continuum of the violations that occur in the wider context of structural inequality, discrimination and patriarchy (...) as well as lack of respect for women's equal status and human rights".[3]

Rights of women and birthing people

Violence during childbirth not only violates the **rights to live a life free from violence** but can also threaten the **rights to life, health, bodily integrity, privacy, autonomy and freedom from degradation and discrimination**.

These rights are established under the **European Convention of Human Rights**, Articles 2, 3, 8 and 14.

The UK **Human Rights Act 1998** incorporates into domestic law the rights protected by the ECHR. All public bodies, including NHS Trusts/Boards have a direct duty to uphold this Act.

In ***Montgomery v Lanarkshire Health Board (2015)*** the UK Supreme Court affirmed a women's right to autonomy and articulated what conversations that uphold autonomy by facilitating informed consent must look like across all healthcare.

The UK is also party to the **Convention on the Elimination of all forms of Discrimination against Women (CEDAW)**. The Convention, as well as General Recommendations 24 and 35, prohibit pregnancy-related discrimination and oblige signatories to ensure safe pregnancies, childbirth and post-partum periods.[4]

[3] A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence : (un.org)
[4] General comment No.24
General recommendation No. 35 (2017) on gender-based violence against women, updating general recommendation No. 19 (1992) | OHCHR

Rights are under threat

More than a decade of austerity has led to maternity services struggling to retain healthcare staff. A dangerous precedent was set through restrictions during the Covid-19 pandemic meaning that **basic maternity rights remain under real and immediate threat**.

The most marginalised women and birthing people including those from racially minoritised communities, those who are LGBTQ+, Deaf and disabled, have English as an additional language, do not have British citizenship, who are in prison or detention, face even more barriers accessing basic maternity care.

Breaches of fundamental rights:

- **Coercive or non-consensual vaginal examinations and medical interventions** – a hospital guideline that a vaginal examination is required before admission to labour ward meant one woman contacting us was told **if she did not consent to a vaginal examination "she would be giving birth in the car park"** and a respondent in our Race Inquiry told **despite their request to not have an injection for the delivery of placenta, it was administered anyway. They became aware of it through the feeling of the needle**.
- Conversations during care that **fail to facilitate informed consent** due to lack of time and good quality interpreters or because HCPs have not been given a confident understanding of the precedent set in Montgomery v Lanarkshire
- **Midwife-led units and home birth service closures, or restricted access** with blanket policies that do not consider individual needs, mean someone deemed "high risk" could include a marginalised and traumatised person with a BMI just one point over a locally set threshold, and who will never consent to coming on to the labour ward, giving birth alone, **denied any community-based midwifery attendance in labour**.
- Disproportionate restrictions on partners, for example in January 2024, we received a case where a Trust **requested a father to leave just one hour after his partner gave birth, due to "covid restrictions".**
- Poor care in postnatal wards. One mother **left lying in her own blood and urine** without a dressing or catheter change for many hours, her calls for aid being dismissed with disparaging remarks.
- **Multiple attempts at forceps when a woman was screaming at the doctor to stop due to the anaesthetic** not working;
- **Episiotomies without consent nor warning, nor anaesthetic**;

The Covid-19 pandemic deepened the systemic failures. Some examples are **restricted access to pain relief, being left to give birth alone** due to **restrictions on partners, suspension of maternity services** (including home birth and midwifery-led birth centres), **mothers being separated for days from their newborn** babies in NICU (in one example she was locked in her room, due to suspected "close contact" of someone with COVID). These set a precedent for continued breaches that we are facing now.

Implementation of Laws

There is **a lack of understanding** by those who design, regulate, commission, manage and deliver maternity **regarding how UK human rights law applies in maternity care and why human rights law is critical to the delivery of safe care.**

Most marginalised communities are more likely to have their rights violated. More on this is discussed below. Here, we want to underline that the disparity in outcomes for Black and Brown women are often viewed through the lens of failures in individual trust/hospital policies rather than systemic issues. Our Race Inquiry demonstrates that systemic racism is a key driver in the disparities. These combine to contribute to community and societal trauma and distrust in the healthcare system.

These systemic issues affect the healthcare staff as well. In our training with frontline HCPs we often hear how guidelines (particularly those developed during COVID-19) and resourcing pressures require healthcare staff to work in ways that they feel is counter to safe care. The most prevalent issues are staff shortages, as well as burnout, stress, moral injury and decision to leave the profession among the staff.[5]

Equal Treatment

There is a major racial disparity among the poor outcomes of systemic failures. Our Race Inquiry revealed that feeling unsafe during maternity care was the most prominent theme in the testimonies we received, with **two thirds of Black, Brown and mixed ethnicity people who shared their stories describing not feeling safe some or all the time** and that racism and racial discrimination had a direct impact on their sense of safety.

Systemic racism causes failure to identify serious medical conditions due to lack of awareness of how to identify the symptoms in Black and Brown bodies, alongside racial microaggressions, stereotyping and discrimination, meaning **concerns are dismissed, pain ignored, relief denied, and consent breached.** One respondent in our Race Inquiry shared how sepsis symptoms she was experiencing and informing the HCPs about, in this case paleness and loss of colour in the skin, were not recognised due to her being a Black woman. Women in prison share with us that their decisions are not respected and "**everything was just decided for me**"[6]; and there are tragic examples (such as Aisha Cleary[7]) of women in prison who do not receive the care they need in a respectful or timely fashion. Refugee, asylum seeking and undocumented migrant women face extra barriers and are not always able to make informed decisions **due to the lack of good quality interpretation services**.[8] There is **the lack of**

[5] The Nursing and Midwifery Council (nmc.org.uk)
[6] Disadvantage - Birthrights
[7] 'Serious failings' contributed to baby's death in 12-hour lone prison birth | Prisons and probation | The Guardian
[8] RCOG Position Statement: Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women | RCOG

choice and control over decision making that is experienced more intensely by disabled women compared to non-disabled women.[9]

Transparency and Access to Justice

At a local level, instead of transparency and accountability what we see is ringfenced budgets for clinical negligence claims and we hear accounts of legal departments influencing clinical decision making about individuals.

Those wishing to complain are faced with a retraumatising and expensive process. There is no legal aid for bringing such cases against the NHS. Non-consented touching does not attract high sums of damages which can deter firms from taking such cases. It can take a very long time for the legal process to be finalized and a sense of justice cannot be reached.

Data Collection

NHS fails to consistently record trans or non-binary status in perinatal services (or in any of its services).[10]

The Patient Safety Incident Response Framework grants Trusts autonomy on which patient safety incidents to investigate. We are concerned that this could lead to trusts deliberately choosing not to investigate incidents which involve ethnic inequalities, which could skew the data regarding patient safety.

Recommendations

- To eliminate violence experienced by women and birthing people in maternity care, **human rights must be centred** in how maternity services are funded, delivered, designed, managed and regulated by the Government so that bodily autonomy, self-agency and informed decisions are respected
- Government should ensure that all decisions made by Trusts must take account of **the disproportionate impact on some women and birthing people** including Black and Brown women and birthing people, LGBTQIA+ people and those with additional and specific needs such as those living with trauma, disabilities, and/or neurodiversity.
- **Interpreting services must be high quality and appropriately regulated** so HCPs have the necessary tools to ensure that women and birthing people can have the information they need to make informed decisions.
- Rights-respecting care cannot be delivered, and violence experienced by women and birthing people cannot be eliminated without sufficient **meaningful investment in maternity services and transparency in decision-making**.

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[9] Access and quality of maternity care for disabled women during pregnancy, birth and the postnatal period in England: data from a national survey | BMJ Open
Final report in pages (birthrights.org.uk)

[10] Improving Trans and Non-Binary Experiences of Maternity Services - Mid and South Essex Integrated Care System (ics.nhs.uk)