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Maternity care: a human rights issue?

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Women's human rights

In 1995 the United Nations 4th World Conference on Women stated that: "The human rights of women include their right to have control over and decide freely and responsibly on all matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence". (UN 1995) Whilst many assume that in developed countries like Australia women receive the best possible maternity care, including respect for their right to have control over and determine their own basic reproductive choices, in fact women's choices are often restricted to those options that governments and certain health professionals want to provide. These options are at present guided by a culture of medical dominance and popular myth, or maintaining the status quo. In other words, the types of maternity care available to women are not necessarily the most likely to benefit consumers. A comment by the United Nations Population Fund (UNFPA) on the importance placed on women's needs applies not only in developing countries, but also, in different ways, in Australia. It states that "women's needs often do not rank high on government's or communities' list of priorities. Women still lack full power to choose the care they want... in many settings available safe motherhood services cannot meet demand because of distance, cost or socio-economic factors. Too many women are still seen as not worth the investment." (UNFPA 2004:52).

Is hospital the answer?

Having quoted from the United Nations (1995) statement on women's rights in matters of sexuality and reproductive health, we note that there is potentially conflicting advice from the UNFPA, which suggests that all women should give birth in hospital (UNFPA 2004:51). In seeking to improve maternal outcomes in developing countries, the report claims "maternal mortality reduction programmes should give priority to the availability, accessibility and quality of obstetric facilities. All countries that have reduced maternal mortality have done it through a dramatic increase in hospital deliveries" (UNFPA 2004:54). In understanding what constitutes effective maternity care in any country, we assert that improvements in outcomes have not resulted simply from increasing rates of hospital births, but from access to appropriate hospital-based emergency obstetric services for those women who experience obstetric complications. A recent WHO/UNICEF report on antenatal care in developing countries(WHO 2003) concludes that "few life-threatening complications can be prevented antenatally, most requiring interventions at the time of delivery and the immediate postpartum period." Most safe motherhood programmes therefore currently stress timely access to emergency obstetric care and ensuring that "all women benefit from the care of a skilled health care professional during delivery." Primary maternity care facilities and providers can safely be low-tech community- and midwifery-based services without on-site surgical options, including the woman's own home. The safety of such primary care comes through understanding and working with the natural process on an individual basis for each woman and without chemical stimulants or analgesics at the primary care level. The midwife or other professional birth attendant arranges timely transfer to a facility that is able to provide specialist obstetric services when there is a valid reason to interfere with the natural process. We stress here the importance of the midwife as primary care provider for most women. Current reliable guidance on the scope of practice of both the obstetrician and the midwife is that "it is inherently unwise, perhaps even unsafe, for women with normal pregnancies to be cared for by obstetric specialists, even if the required personnel are available… Midwives … on the other hand are primarily oriented to the care of women with normal pregnancies and are likely to have more detailed knowledge of the particular circumstances of the individual

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woman. The care that they can give to the majority of women will often be more responsive to their needs than that given by the specialists" (Enkin et al 1995:21). Yet medical control of pregnancy and childbirth is widely accepted, particularly in English-speaking countries and others influenced by British colonial advances in past centuries. By contrast, responsibility for basic maternity care in the Netherlands is the work of midwives, who identify women in need of specialist medical care, and send them to obstetricians through a referral process.

Maternity care in Australia – contravening human rights?

Birth is not an illness, yet usual care in pregnancy and birth is indistinguishable from that provided to sick people. The maxim promoted by the World Health Organisation, that "in normal birth there should be a valid reason to interfere with the natural process" (WHO 1999), is often ignored in health systems which treat birth as a medical condition and which constantly seek better machines and drugs. Countries like Australia which have embraced medical control of childbirth, with virtually all births being managed in hospitals with on-site surgical capacity, have experienced a steady escalation in caesarean births, with no sign that the increasing rates are likely to plateau or fall, or improve maternal or infant outcomes. Australia's caesarean rate is fast approaching 30% (AIHW 2004:xiii). This compares with countries like Sweden and Denmark whose caesarean rates are around 15%. Holland's rate is as low as 12% (Birthchoice), mainly because high levels of midwifery care have been maintained and low-risk women are directed in pregnancy to midwife care and homebirth (Smulders). Spontaneous onset of labour, one of the key predictors of likelihood to proceed to a spontaneous vaginal birth, is becoming less common in Australia, as only just over half of all women now go into labour without medical assistance (AIHW 2004:24). The ability of any mammal to progress safely in labour can be impaired by interruptions that interfere with the natural ability to give birth. Fear or anxiety in the mother can cause a slowing or stopping of labour, and adversely affect the fetus; when in a quiet, unstimulating environment the same mother could often have proceeded without complication. Many women today, who would otherwise be able to give birth unaided, experience such interference, leading to a cascade of interventions in standard hospital-based maternity care. Australia's health funding system has given medical practitioners a monopoly of maternity services, even though obstetricians are surgeons who are not necessarily expert in uncomplicated birth. The role of the midwife has diminished, in many maternity services, to that of assistant to the obstetrician, and a technician who keeps the machinery working.

A culture of fear

While the medical establishment repeatedly cites 'risk factors' to justify medicalised childbirth for every woman, much of the medical intervention actually introduces new risks when applied to the majority of women who have normal pregnancies and births (Odent 1984:94). The worldwide phenomenon of increasing rates of caesarean birth is a result of the prevalent culture of reliance on medical care, and the subsequent loss of trust in the natural process and loss of midwifery skill, together with pressure to submit to medical management of the childbearing process. Medical interventions themselves each carry a set of risks, including infection, adverse drug reactions, human error, and surgical mistakes and haemorrhage. The widespread use of intervention and technology has created fear and doubt about the adequacy of the female body, and reinforces distrust about the reproductive powers of women, contributing to a 'culture of fear' about childbirth (Canadian Association of Midwives 2004). As more interventions occur, more women fear giving birth under these conditions. Even women who are deemed low-risk turn to obstetric specialists to 'save' them from the natural process of vaginal birth, and often experience interventions as they do so, escalating the vicious circle of intervention and fear. Considering that up to 80% of women can have an uncomplicated birth, there is a pressing need to educate women to understand their own innate ability to give birth, and to increase women's access to midwives who will provide continuous care.

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Freedom from violence

When considering a woman's basic need to be free from violence, we in developed countries ay refer with abhorrence to practices of ritual genital cutting, child brides, and under-age prostitution in less advantaged places. Yet we tolerate the practice of episiotomy (Shorten & Shorten 2004), which occurs in about 16% of vaginal births in Australia, and up to 21% in Victoria (AIHW 2004:38). Instrumental vaginal births, with associated potential for serious injury to the woman's bowel and bladder continence, are more likely in births attended by specialist obstetricians in private hospitals than in public hospitals (Roberts et al 2000).

Control over reproductive health decisions

All women need the ability to access midwifery-led care at the primary or first level of care, enabling them to *have control over,* and *decide freely and responsibly about, their reproductive health.* In establishing women's control of their own reproductive health, there is likely to be a reduction in reliance on unnecessary interventions in birth. The choices of maternity care provided in Australia are at present discriminatory. On the pretence of fundinglimitations, community based midwifery-led models of care are not widely available. Such options are limited to so called 'alternative birthing' arrangements for a limited number of women, mainly in low socio-economic groups or 'at risk' groups such as teenagers and Aboriginal women. Whilst the increased mortality and morbidity rates, and poor social circumstances, of women in these groups clearly demonstrate their need for better care, these women may be further marginalised by being identified as needing special attention. Furthermore, we argue that a strategic reallocation of present funding from mainstream medicalised care would enable all women to access midwifery-led models of care, which are not only generally more cost effective than standard care but importantly offer them the option of choosing one-to-one midwifery (Maternity Coalition 2002). Until Australian governments stop limiting the real maternity care choices available to women, and make a political commitment to provide care based on consumer needs, rather than health professionals' preferences, Australian women will not be able to exercise their fundamental human right to decide freely on matters related to their reproductive health, for these decisions are currently strongly constrained by what governments are prepared or encouraged to provide.

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