THE UNIVERSITY OF SYDNEY

HUMAN RIGHTS in CHILDBIRTH

Select Committee on Reproductive,
Maternal and Paediatric health services
in Tasmania
c/o The Hon. Ella Haddad MP
Chairperson
TAS Parliament House
4 November 2024

Dear Minister Haddad,

We thank the Committee for giving us the opportunity to report on the nature and causes of mistreatment of women and pregnant people accessing maternity services in Tasmania.[1]

Human Rights in Childbirth (**HRiC**) is an international, not-for-profit legal and human rights organisation founded in The Hague in 2012 to monitor and report on human rights abuses in pregnancy and childbirth. We report such abuses to the World Health Organisation and the UN Special Rapporteur on Violence Against Women. The organisation is led by a board comprising obstetricians, midwives, consumers and human rights lawyers from Australia, Latin America, Eastern Europe, USA and India. We do not receive any funding or fees for our work.

We have been receiving and documenting reports of abuse and mistreatment during the provision of maternity health services at the facility level in Australia for over 11 years. We also document reports from health care providers and support persons whose employment or income is threatened for protecting women in their care, and women facing child removal threats and/or law enforcement for refusing medical treatment while pregnant.

We have, in this report, documented (in blue text) just some of quotes from women and careproviders in Tasmania who have reported, in most instances, shockingly abusive care received over the last two years at the hands of careproviders at maternity hospitals in Tasmania.

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[1] For inclusivity, we use the words "women" and "pregnant people" interchangeably.

The extracted quotes provide evidence of serious assault and battery *and, in most instances, unsupervised incompetence* which should have been reported to the police and Ahpra, together with steps taken to either discipline and/or terminate the employment of the perpetrators.

In addition, there appears to be a pattern of inducing women and performing highly interventionist procedures for convenience and financial gain, without informed consent. This is done either by falsely claiming the procedures are mandated or misleading women into believing the forced treatment was justified. This is not just an unnecessary burden on public health system both in terms of unnecessary maternity procedures and the need for follow up care, there appears to also be a total disregard for the human and legal rights and wellbeing of the women and babies. The costs of seeking follow up care for serious injuries is being shifted onto families, with public facilities showing little to no interest in women's complaints following the birth. It is incredibly concerning that there is no accountability or transparency in relation to the unlawful behaviours reported to us.

Please see below our detailed submissions on the way in which maternity health services in Tasmania violate women's legal and human rights as a normalised, systemic daily process.

We would be happy to share any further information or respond to any questions the Committee may have in relation to our submissions and/or our work.

We urge the Committee to take immediate action to remedy this harmful culture of systemic and unrestrained obstetric violence.

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HUMAN RIGHTS in CHILDBIRTH

Tasmania House of Assembly Parliamentary Inquiry into Reproductive, Maternal and Paediatric Health and Perinatal Mental Health Services

Executive Summary

Obstetric Violence is a legal term and refers to the abuse and mistreatment of pregnant women and people in maternity health facilities as a systemic, normalised, everyday event embedded in institutional and obstetric culture and practice.

The provision of health services which violate the human rights of women is poor quality care.

Obstetric violence has, amongst other things, caused women to suicide or attempt suicide, self-harm, reject their infants, suffer PTSD, anxiety and depression, suffer relationship breakdowns, lose their jobs, lose their homes, lose their children, relinquish their careers, struggle to re-enter the workforce, incur significant out-of-pocket costs seeking psychological or psychiatric care or specialist care for nerve damage, pelvic floor injuries, surgical complications and third to fourth degree perineal tears, endure faecal incontinence, terminate pregnancies, reject careproviders and vaccinations, become isolated and suffer domestic violence.

There is substantial evidence of women being abused, mistreated and overserviced to protect financial interests, convenience and incompetence.

Disrespect and abusive treatment are not limited to the intrapartum period (ie labor and birth). Incidences of abuse have been reported from the moment a woman's pregnancy has passed its first trimester to well after the infant has been delivered. It is driven by hospitals and careproviders, and facilitated by the police, ambulance services, primary health networks (ie GPs), and child protection services.

Abuse and disrespect are not confined to the woman. They are also directed at any person seen to be supporting a woman perceived as non-compliant to careprovider demands. Indigenous, refugee and immigrant families, trauma sufferers, people with disabilities, and women who engage the services of doulas and/or privately practicing midwives are especially vulnerable to such abuse.

Many careproviders show limited to no understanding of the legal and reproductive health rights of competent, adult women, and rely on discrimination, harmful gender stereotypes, the doctrine of medical necessity and institutional power to justify coercive and abusive behaviours.

Reports from Tasmania indicate that careproviders are also deliberately avoiding their obligation to obtain informed consent.

Discriminatory medical liability laws, legislation and professional regulators shield careproviders who violate human rights and diminish the significance of abusive behaviours with absolute impunity.

The Coroner's court, police and child protection services have helped to foster that culture of impunity around facility-based abuse and to normalise obstetric violence and associated violations of women's fundamental human rights.

Australia, and its governments, are obliged, under the Convention on the Elimination of All Forms of Discrimination Against Women, to:

- Provide quality health-care services i.e. services that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and issensitive to her needs and perspectives;[1]
- Adopt legal and policy measures to protect pregnant women from and penalize obstetric violence, strengthen capacity-building programmes for medical practitioners and ensure regular monitoring of the treatment of women in maternity healthcare centres and hospitals;1
- Take all appropriate measures to modify or abolish not only existing laws and regulations but also customs and practices that constitute discrimination and the endorsement of harmful gender stereotypes against women;1
- Establish, publicise and implement a Patients' Bill of Rights, with access to effective remedies in cases in which women's reproductive health rights have been violated, including in cases of obstetric violence;1
- Provide specialized training to judicial and law enforcement personnel to recognise structural discrimination based on harmful gender stereotypes regarding pregnancy and childbirth;1 and
- Mandate human rights and legal training for obstetricians, midwives, other health professionals and administrative bodies focussing on women's reproductive health rights, obstetric violence, harmful gender stereotypes and adherence to the Patients' Bill of Rights.

1. Obstetric Violence Is A Term Of International Law

Obstetric Violence is a term of international law, declared by CEDAW and reinforced by precedent caselaw. Australia is a signatory to CEDAW and its protocol. This means complaints can be brought to CEDAW against Australian governments for failing to take steps to protect women from institutional obstetric violence.

There is currently an objection by institutional careproviders – led by medical and midwifery leaders respectively - to the use of the phrase "obstetric violence". Many seek to instead use the phrase "birth trauma". Birth trauma refers to the *consequences* of mistreatment and abuse[2], which we have outlined in Part 9 of this submission. It shifts the focus away from the problem of obstetric violence and its causes.

From a legal perspective, the objection is as odd as an objection to the phrase "domestic violence" and, unfortunately, reveals more about those objecting than about the legal phrase itself. The objection is a deflection from the serious problem of careproviders openly engaging in abuse and mistreatment of women in Tasmania. It is a worrying signal of a refusal by providers to take responsibility for their violent behaviours.

We note that the Commonwealth Government, in keeping with its obligations under CEDAW.[3]

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[2] Maria TR Borges, "A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence" (2018) 67(4) *Duke Law Journal* 827-862.

[3] Australian Government, "Obstetric Violence" <https://www.pregnancybirthbaby.org.au/obstetric-violence> accessed 4 Nov 2024.

In international law, "Obstetric Violence" is defined as:

…the mistreatment and violence against women experienced during facility-based childbirth… [which] has been shown to be widespread and systematic in nature.

The phrase "violence against women" is defined, under Article 1 of the Declaration on Elimination of Violence Against Women, as:

> …any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[4]

In its *General Recommendation No 35 on Gender Based Violence Against Women*[5], the Committee which monitors the implementation of rights enshrined in the Convention on the Elimination of All Forms of Discrimination against Women (**CEDAW**), to which Australia is a contracting party, defines "*violence against women*" as '*violence which is directed against a woman because she is a woman or that affects women disproportionately*'. Such violence constitutes discrimination and a violation of women's fundamental human rights.[6]

The Committee went on to say the prohibition on violence against women is non-conditional and:

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[4] Declaration on Elimination of Violence Against Women, GA Res 48/104 (Adopted 20 Dec 1993) <https://www.ohchr.org/en/instruments-mechanisms/instruments/declaration-elimination-violence-against-women>.

[5] Committee on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, UN Doc CEDAW/C/GC/35 (26 July 2017).

[6] Committee on the Elimination of Discrimination against Women, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, UN Doc CEDAW/C/GC/35 (26 July 2017), [1]

> "[t]he opinio juris and State practice suggest that the prohibition of gender-based violence against women has evolved into a principle of customary international law."[7]

The Special Rapporteur for Violence Against Women (**Special Rapporteur**) observed in her Report, *A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus On Childbirth and Obstetric Violence,* to the UN General Assembly (**OV Report**):

> … the main issue at the core of obstetric violence is the systematic deprivation of women's right to autonomy once they are in contact with a health-care facility.
>
> That deprivation can take many forms, going from the most obvious, such as the practice of an operation despite the lack of the woman's consent, to some more insidious forms like the application of so-called 'hospital protocols'….[8]

Obstetric violence broadly falls into two categories[9]:

- Interpersonal behaviours of individuals manifested through physical and verbal mistreatment, humiliation, lack of information and consent, the abuse of medicalization and the pathologizing of natural processes; and

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[7] Committee on the Elimination of Discrimination against Women, *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, UN Doc CEDAW/C/GC/35 (26 July 2017), [2].

[8] Dubravka Šimonović, A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, A/74/137, Report of the Special Rapporteur on Violence against Women, 74 sess, Agenda Item 26(a), Supp No A/74/50, UN Doc 19-111859 (E) 130819 (11 July 2019) (***OV Report***).

[9] MA Bohren et al "The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review (2015) 12(6) *PLoS Med* e1001847.

- Dehumanising systemic actions, structures and policies[10];

that lead to women's loss of freedom, autonomy, and the ability to freely make decisions concerning their body and sexuality.

The two categories share a symbiotic relationship. The abusive interpersonal behaviours of careproviders are structurally and systemically reinforced, in that they are enabled and sustained by a number of institutions, policies and guidelines, and medical liability laws and legislation.

2. Types of Obstetric Violence

Obstetric Violence manifests as physical abuse, verbal abuse, non-confidential care, non-consented care, false and misleading claims, discrimination and abandoning care.

We provide details of the type of abuse that falls under each of the aforementioned categories, together with some of the direct quotes from Tasmanian women below:

PHYSICAL ABUSE	
1.	Authorising security guards to physically restrain a woman resisting a forceps delivery
2.	Mandating or enforcing continuous fetal monitoring which physically immobilises and confines women to the bed
3.	Withholding food and water during labour in anticipation of performing a Caesarean Section (**CS**)
4.	Withholding pain relief, including to obtain compliance

[10] M Sadler et al, 'Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence' (2016) 24(47) (2016/09/01) *Reprod Health Matters* 47-55.

	I was denied an epidural & was then cut with scissors with no numbing while having my daughter.
5.	Forcibly removing women from the shower or bath (used as pain relief) because the doctor wants them on the bed
6.	Forced treatment such as: - Manual revision of the uterine cavity without pain relief - Forcing a fist and arm into the cervix without pain relief - Attempting to sterilise a migrant woman during a CS - Collective or repeat digital vaginal examinations for refusing a CS [redacted]
7.	Vaginal examinations without consent

I was a first time mum, I was only 20 years old and I was scared. I didn't know what to do. As a survivor of child sexual abuse, I had asked to be attended by only female staff. I was dismissed and ignored. Instead, I had a male doctor. He was dismissive of me and didn't listen to me at all. He performed a vaginal examination on me, by inserting his fingers, without my permission or consent.

8. Episiotomies without consent

I remember at one point absolute searing pain in my vagina (which I later found out was them cutting me to make room for the doctor to insert either his fingers or hand to manoeuvre my son's shoulder).

...After waiting for over 2 hours, a doctor finally came in to stitch me up. She said it was a bad cut, but that she could fix it. [13 months later] I had a prolapse where my bowel was prolapsing

into my vagina. My gynaecologist said... that there is a huge chance it has resulted from my Episiotomy not being treated correctly afterwards.

Then the midwife in the room told me that the doctor had made a cut and that I would need stitches. He had given me an episiotomy without my knowledge let alone without my consent! I could feel the stitches, so painful. And he was shoving gauze into me, I guess to soak up the bleeding, shoving it in violently. I voiced my pain but he said nothing and kept doing what he was doing.

9. Expedited cord clamping without consent

[redacted]

[We note here that the evidence, endorsed by the WHO and

	the Lancet, shows that delayed cord clamping is best practice. It requires no more than a few minutes of patience and respect, and the health benefits for both mother and baby are significant. Expedited cord clamping without consent is a strong example of provider practice driven by convenience over best practice and human rights.]
10.	Requiring Indigenous women, immigrant and refugee women to follow protocols incompatible with their cultural background
11.	Isolating or confining women to a room as a means for obtaining compliance to treatment
12.	Withholding pain relief as a punishment or form <u>of</u> trade-off for compliance *[The midwife] then stated that I could have a birthing suite and my partner could come in (both at 6am) if I PROMISED to take the drip if my contractions stopped. I thought this was tantamount to* *blackmail. But I agreed because I knew the contractions were not going to stop and I wanted my partner and a birthing suite.*
13.	Issuing medications <u>without</u> knowledge or consent *"An hour later I was wheeled up to the NICU. They had plugged [my baby] into antibiotics (without any testing, profilactic antibiotics without consulting myself or my partner). She hadnt required rescuss, so Im not sure why they had to take her away - "Just a precaution" or "Just to be on the safe side." I was told."* --- *"I was given 2 doses of Morphine instead of 1 causing me to have vomiting & be disoriented & causing my daughter to stop breathing after she was born multiple times needing resuscitation. ...After birth I was found wandering the hallway alone looking for my daughter. I was only checked on once by a midwife after I had given birth."* --- *"I said 'Oh, they've given me a tablet when they gave me my needle,*

but I don't know what they gave me.' "[My mother] actually pressed the buzzer because she was a bit concerned. And they [hospital staff] came in and said, 'Yeah, we gave her antidepressants because she was upset and crying.'"

DISRESPECT AND VERBAL ABUSE

1.	Reacting to perceived challenges to a careprovider's power and authority with a range of defensive measures, eg storming out of the room, eye-rolling, jokes, verbal abuse, threats, taunts and infantilising statements: eg: "You silly, stupid girl" "It's time you got a reality check" [To an Indigenous woman] "I think you need to learn how to say please and thank you"; *"When [the anaesthetist] arrived she was visibly and audibly angry. She had just finished a shift at the hospital only to be called in again for my epidural. She raged at the midwife about this. She then yelled at me for moving whilst she tried to insert the needle in my back, at this stage I was still having contractions one minute apart so it wasn't really possible to hold still. She snapped about several things, if I spoke she would snap back at me, she just wanted to chat with the midwife about their weekends and complain about other staff whilst I lay on the bed seriously distressed.* *By the end of all this messing about they called an emergency saying the fetal heart rate dropped, a tonne of people descended on the room and Dr [redacted] got out his forceps. Due to the forceps I sustained a prolapse, a tear, and bladder issues that have lasted 6 years so far."*
2.	Asking family members, spouses or doulas to get a non-compliant woman under control and blaming them for 'interfering' if they refuse *"3 hours later I caved and agreed to the epidural. Although I had specifically asked them in my birth plan to never hassle me with interventions,* ***my midwife kept saying to my mother "If it was my daughter I'd suggest she got an epidural."*** *Which I have since learned is a common work-around to be able to push interventions indirectly."*

3.	Shroud waving: "Your baby is going to die and that's on you" "You don't want your baby to die, do you?" "A baby died in this room yesterday, let's not make that happen again - understood?" "I don't have time for this. Call me when she is ready to save her baby's life" *...the Dr harshly said, " if you don't start pushing properly, yes your baby will die" I looked at baby's father and said, "I'm sorry" and my body gave up. Completely defeated, luckily my body then kicked into gear and with one last push my miracle baby was finally safe earth side . With no help from that Dr. I was doing my absolute best, she said her reasons for saying that is so that I would push harder. It had the opposite effect, and I wish no one the pain of being told there baby will die due to their own fault of "not pushing properly"*
4.	Badgering to get the desired response: "You've had five minutes to think about this, are you ready now?" "What's the problem? Why are you wasting everyone's time?" "The doctor is waiting!"; "So have you decided to go ahead yet?" *[After repeatedly asking me to breastfeed], the nurses weren't overly supportive of [my decision to express milk] and threw a breast pump starter set at me on the bed and said here you go. Expecting me to just know what to do with it. I had no idea what to do or how to even get started. I was crying and no support or care was shown.*
5.	Scolding for doing something the staff don't approve of, such as getting off the bed, moving around the room, asking for water, crying or vomiting: "This is really unnecessary – tone it down!" "That's disgusting. Why did you do that?" "You stay there, young lady. You better not move until I say so"

	"Do you have any idea what you are doing? You are going to be a mother!"; *"...we were being "looked after" by a particular midwife who was absolutely awful, and I do not use that word lightly, her attitude and care towards me in such a vulnerable time was devastating... Making me feel like I was starving my child because I was unable to get her to latch, to then telling me my daughter isn't hungry and taking her out of the room so I could pump. Her unwanted comments, her behaviour was unacceptable, and I never called her back into the room again if I needed help.""* --- *"...after the birth, I was crying in my room ...because I was in so much pain, so tired, and so confused and traumatised. The midwife walked in, saw me crying and said "Well crying wont get you anywhere so you can stop that right now." ... It was easier (or less heartbreaking) to just not ask for any help."* --- *I asked if anything was happening while crying (I was exhausted, I'd been contracting for 72 hours prior to attending the hospital), I received a "Well you're not pushing, so what do you expect?"*
6.	Threatening or ejecting fathers or doulas for trying to protect a distressed woman: "Calm down please or we will have to ask you to leave" "You can either help or get out, now".

NON-CONFIDENTIAL CARE	
1.	Refusing to close the birth suite door, allowing several people to enter without warning and/or permission
2.	Complaining at the nurses' station about particular women *Before my birth, I had attended the pregnancy assessment multiple times due to issue regarding BP and reduced movements, to be told every time everything was normal on their machines. I was sitting in my bed when I heard 2 midwives and a doctor talking about myself in negative ways about my decision for wanting to go home the next day.*
3.	Sharing personal information about women refusing care with local GPs, the police and DCJ, without their knowledge or consent
4.	GPs 'reporting' women planning homebirths to hospitals and the local sheriffs (a feature of regional hospitals)
5.	GPs obtaining a woman's personal information, including her home address, from hospital staff and corresponding with the woman against her wishes
6.	Hospital staff gossiping about women who transfer from a homebirth, particularly in regional hospitals of small communities

NON-CONSENTED CARE

1.	Mandating CSs, inductions, forceps, continuous fetal monitoring and vaginal examinations 
2.	Performing procedures *before* consent is given *With my second birth in 2022 when it came to push I was given an episiotomy without my consent. I was then stitched up by a student doctor without being asked if she could do it. I was not told it was a student doing the stitches and only found out after she was done and said "**thank you for letting me practice on you**".*
3.	Abusing the legal doctrine of implied consent *...my midwife decided it's probably better to put the monitor on that goes on the tip of bubs head. While it may have been common sense, everyone failed to mention that this process broke my waters, and I didn't even consider that as I was in and out of contractions. I did not consent to having my waters broken*
4.	Deploying procedures without prior disclosure or proper informed consent *I have since read up and found out that when shoulder dystocia has occurred, a doctor or nurse should sit down and explain everything and check in how the parents are going mentally. Answer any questions you may have. I have also read on some pamphlets about shoulder dystocia, that the mother is meant to be taken to theatre to check for 3rd or 4th degree cuts or tears.... it certainly didn't happen with me.*
5.	Forcing women who refuse treatment to undergo and/or threatening them with psychiatric assessments
6.	Threatening to call or calling *Strong Families Safe Kids* if women don't comply, question or refuse treatment

FALSE AND MISLEADING INFORMATION

1. Biased and/or misleading information to coerce an institutionally preferred outcome

> *...at the start of the second week I got a call asking me to attend an insulin information class. I said I didn't want to be on insulin until I have bsl data ... and I wanted to speak to an endocrinologist, this...was booked, [but] by then...my levels had stabilized to within acceptable limits, and I was told I did not need insulin. ...*
>
> *Dr [redacted] at around 34 weeks said we would discuss induction at 39 weeks I was surprised. Said I didn't want induction, especially if [baby] was already small.... next doctor at 36 weeks simply agreed that there wasn't a need to induce for such a small baby.... Next visit, 38 weeks, I was told I would need to have an induction the following week because of my Gestational Diabetes. I told her what the last Dr had said, and she replied that there's also a risk the placenta may be deteriorating. [But I ask] wouldn't we notice that with a blood sugar drop? Or have seen signs of that on the ultrasound? Not necessarily, she said.*
>
> *I reiterated I wanted there to be real evidence of medical reasons why I needed to be induced. Because she didn't have any we agreed to no 39 week induction. Then she said I would have to be induced at 40 weeks because of my age. I was confused, no one had said this to me yet, and she spent 10 min telling me about increased stillbirth rates among women my age for every day over 40 weeks. I asked for the data on that, she didn't have it so got [redacted] who oversees the ward, to come tell me the numbers.*
>
> *As she was talking, I kept hearing "40" and it took me a bit to realize she was saying over 40 weeks AND over 40 years... so I interrupted her and said I only just turned 39, I'm not over 40. She looked at the other doctor, who looked at the computer, and said she made a mistake, I'm 39. 20 minutes of being stressed and talking about stillbirth rates because she read my chart wrong.*

2. Evasive responses to questions about VBAC, waterbirth, delayed cord clamping, skin to skin with the newborn, continuity of midwifery care

> *...we talked about the birthing bath - a major part of my birth plan. She said that wouldn't be an option for me because they would*

want extra monitors on me because of the GD. I asked if GD impacted my ability to use the bath. I said if that was the case, I would decline the monitoring. ***She said I might not have that choice, it depended on the medical staff in the room****. This is the first I'd heard of me "not having a choice" in how my labour went and it threw me. In the end she checked with someone else and discovered that as diet controlled GD, I could indeed use the bath. More unnecessary stressful conversation at 38 weeks.*

3. Abusing the doctrine of medical necessity [i.e. falsely claiming an emergency];[11]

I experienced a long labour with my first baby which stalled at 7cm with no progress over many hours. The doctor told me that my baby would get tired and there was a risk of bleeding and fatal distress if my labour continued. They recommended a category 1 caesarean section which I agreed to. I was then left with an ineffective epidural in the birth suite for over 5 hours waiting to be transferred to theatre. There were so many people in the room. I was in extreme pain and felt like I was going to die. I said this many times to my care providers. When the doctors finally arrived to review me, my baby was ready to be born vaginally. I had an instrumental birth in theatre even though I hadn't pushed at all because I was so exhausted I couldn't speak or move. After this, I had severe postnatal depression that lasted for many years.*

[*A Cat-1 CS is a RANZCOG designation for a CS that must be performed immediately because of risk of **imminent** death or permanent injury to mother and/or baby.]

4. **Bait and Switch**: the practice, particularly in the private sector, of promising to do something and then failing to honour that promise:

A week later we had to return to the hospital with an infection (introduced into my uterus undoubtedly by the several people with their hands in my vagina the week before) and stay another 5 days.

[11] The doctrine of medical necessity limits the provision of medical intervention without consent to situations where the intervention is urgently required to avoid serious harm to the person affected.

	Again, the bedside manner was awful. I had a drip in my arm which had caused my hand and wrist to bruise and swell up. *I had a fever and was extremely unwell. One of the nurses was kind and put the antibiotic in slowly & told me to ask the other nurses to do it slowly too.* *I asked another girl as she arrived in the room at 5am "My arm is extremely painful and the injections are excruciating right now, the other nurse does it slowly over 30-60 seconds so it doesn't hurt, can you please do the same?" She smiled and said yes, then she inserted the needle and injected it within 10 seconds. I was screaming out in pain and was left crying, she said "Its better to just get it over with." And left.*
5.	Withholding resources or referrals (e.g. in relation to breech birth) *I attended PAC for a position check scan, to make sure my baby was not in breech position. Before the scan I was told by the attending Registrar that under no circumstances I could have a natural breech birth at the RHH. Period. I asked why, to which the response was it was unsafe as the staff are no longer trained in breech birth.*

DISCRIMINATION	
1.	Failing to secure an interpreter where needed
2.	Ignoring or mistreating refugee women who are not fluent English
3.	Forcing or mandating treatment on the basis of race or migration status
4.	Profiling and treating women differently by reason of race, sexuality, gender, disability
5.	Assuming that Indigenous people will be intoxicated, incapable of caring for their infants, will cause trouble, are dishonest and/or need to be controlled
6.	Assuming that Strong Families Safe Kids should be notified because the woman is Indigenous
7.	Disrespecting simple requests for cultural sensitivity for e.g. a Muslim woman requesting female careproviders so she can remove her hijab and labour comfortably
8.	Ignoring or dismissing 'unseen' disabilities like trauma, anxiety, mental health issues or chronic pain. *I was left without pain relief for 6 hours, had my colostrum left out and it went off because the midwife was pulled away because they were short staffed and we had one really rude/racist midwife due to the staff shortages.*

ABANDONING CARE

1. Neglect

The day after my c section the nurses made me get up out of bed and go to the bathroom instead of staying in the room to wait for me they left me ALONE! I felt dizzy after returning from the bathroom and fell down trying to get back onto the bed. I had to call the nurses button as I was crying and in pain and needed some help up. They took ages to come in. Absolutely No one liked to come into my room and it was such an effort to them as they all had to gown up from head to two as my test results still hadn't returned.

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*I was left to labour alone **for 35 hours** in a random spare room in the hospital and nearly got sent home because no one was able to help me. I just managed to get into a suite last minute but then 1.5hrs after giving birth I was kicked out of the suite to go to Maternity where I was again left alone for another 12 hours as a first time mum. I had assumed that was a common experience?*

I [then] asked for hours to get my cannula fixed up, ... but 2 hours went and nothing, also when I asked to get up to have a shower, the cannula was that far out when I put pressure on my hand and it burst out, causing blood to go everywhere and no one got me a new blanket as the other one was covered in blood, and I couldn't call to ask.

2. Refusing to provide care because a woman's birth choices are outside hospital policies

The midwife then said she could cancel it but I would then risk 'not being able to come in for an induction if my pregnancy went over'. Note again I was 40 weeks so there was no indication that I would not give birth naturally within the next two weeks etc. I was placed under considerable pressure to have said induction despite there being zero medical reason to have this. The appointment and its events placed me under significant distress and pressure as I did not want an induction. Over the next ten days I had significant mental health issues and as a result I believe I did not go into labour naturally. This I believe was a direct result of the very poor treatment I received in the appointment.

3. Storming out of the birth suite without further discussion and refusing to provide follow up care

> *My high risk Dr was 'too busy' to examine me. My second set of twins, went into labour at almost 35 weeks but instead of theatre because I can't have natural birth was sent home because they didn't have the staff and ended in a complete uterine rupture and the death of my baby girl.*

Fragmented care appears to be standard practice in Tasmania and is overwhelmingly contributing to the abuse and disrespect women are experiencing at the hands of their careproviders. Medical professionals do not attend the labour until a woman is close to giving birth. This means that the current system depends on a highly fragmented structure for delivery of a care, including antenatal care by one group of doctors and/or midwives, hospital birth with another group of midwives, a new doctor (or two) who turns up at the end of the labour, or when called, who feels out of the loop, anxious to take control and ready to blame everyone else if there is a problem. Then another group of midwives who will provide postnatal care and another doctor who will conduct a final check before the woman is discharged. There is no one provider who can confidently say that they have been with the woman, know and understand her needs and wants, and are able to navigate and coordinate care that is respectful to her. In such a fragmented framework, the opportunity to manage minor issues before they become major problems are often missed. Without a relationship with the woman, it is easy to dehumanise and mistreat her – as we show below.

> *My experience with the OBs up until my birth with my daughter in March has been horrible. The follow up from the PMP was done by multiple OBs who all said different things, then when I had another loss, and subsequently had to have follow up again, no OBs called to tell me scan results.*

3. Womens' Fundamental Human Rights

Women in Tasmania, like men, have a right to enjoy, without interference, their fundamental human rights including, but not limited to:[12]

- right to bodily autonomy and informed consent
- right to dignity and equality
- right to life
- right to the highest attainable level of health
- right to privacy
- freedom from discrimination
- freedom from torture, or cruel or inhumane treatment.

Autonomy and consent are recognised legal principles in Australia, and (somewhat ironically) often used against women as a defence in medical liability claims, such as in *Harriton v Stephens*[13], where Crennan J, for the majority of the High Court of Australia, said:

> Such decisions are bound up with individual freedom and autonomy.
>
> The duty of care proposed to the foetus (when born) will be mediated through the mother. The damage alleged will be contingent on the free will, free choice and autonomy of the mother.[14]

More recently, the UK Supreme Court in ***Montgomery v Lanarkshire Health Board***[15], *again* affirmed the right to consent to or refuse treatment:

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[12] Rajat Khosla et al, 'International Human Rights and the Mistreatment of Women During Childbirth' (2016) 18(2) *Health and Human Rights Journal* 131-143.

[13] (2006) 226 CLR 52.

[14] Ibid, [248].

[15] [2015] UKSC 11 (***Montgomery***); see also *Re MB (Caesarean Section)* [1997] EWCA Civ 3093, [30]; *Society of N.Y. Hosp. v Schloendorff* (1914) 211 N.Y. 125; *Secretary, Dept of Health and*

> An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent **must** be obtained before treatment interfering with her bodily integrity is undertaken.[16]

Criminal and civil laws prohibiting assault and battery in Australia are implemented to protect these fundamental human rights for all. The only basis on which *anyone*, including healthcare providers, can touch or attempt to touch an adult is by obtaining informed consent.

4. Understanding Informed Consent

Informed consent is defined, in international law, as follows:

> An intervention in the health field may only be carried out after the person concerned has given **free and informed consent** to it.
>
> This person shall **beforehand** be given appropriate information as to the **purpose** and **nature** of the intervention as well as on its **consequences and risks**.
>
> The person concerned may freely **withdraw consent** at any time.[17]

Women in Tasmania overwhelmingly report that male careproviders perform vaginal examinations without so much as acknowledging them beforehand.

This constitutes assault and battery.

Fundamental human rights are rights that are inviolable, as in there is no proportionality or compromise in relation to respecting those rights.

Community Services v JWB and SMB (Marion's case) (1992) FLC 92-293, 79,172; *Mallette v Shulman* (1990) 67 DLR (4th) 321, 336.

[16] Montgomery n17, [87].

[17] *European Convention on Human Rights and Biomedicine 1997*, Article 5.

The fundamental right to informed consent is underpinned by the fundamental human rights to bodily autonomy and bodily integrity.

In Tasmania, careproviders in both public and private sectors appear to be operating on several mistaken assumptions that violate the legal and human rights of women i.e.:

1. Providers believe, contrary to law, that they do not need to obtain informed consent for what *they* consider to be routine or minor procedures;

When women repeatedly complain that certain procedures are being performed without consent, there can be no justification for the provider belief that they are minor procedures for which consent can be implied. These procedures involve an invasion of a woman's intimate parts. To say that women are impliedly consenting to these procedures is no different to claiming that women who sit on a bed are impliedly consenting to sexual intercourse.

2. Providers assume, contrary to law, that the requirement for consent in relation to 'major' surgical procedures such as cesarean sections (CS) is satisfied when women sign a consent form either under duress, without adequate explanation or through the provision of false information;

The sheer number of women who are being induced for facility convenience is a matter of serious concern. Women are clearly not being informed of the consequences of such interventions and the risks associated with induction. Induction is a lottery. Infants inevitably become exhausted from inductions within a short period of time because the contractions caused by inductions, unlike a woman's body, are relentless and continue regardless of the baby's need to rest. Women are therefore put "on the clock" without being told that is going to happen. In hospitals with fragmented care, women are remotely managed by a centralised CTG monitoring unit. Several women report being hooked up to monitors (without consent) and then left alone for hours. Delivery is then forced either because a careprovider's wants to go home or as soon as the baby shows signs of fatigue. None of the women we spoke with were offered the opportunity to stop the induction so they could rest and let their baby recover. This too is just purely for convenience.

3. Providers assume, contrary to law, that pregnant women do not have the right to refuse treatment.

> *I was screaming for it to stop; I was actually screaming 'stop.' They ignored me, a whole room full of people, they just kept going. I was looking at my partner, he was crying, and I was saying 'this is wrong'.*

This is evidence of assault and battery, actionable under Tasmanian criminal laws.

4. Providers assume, contrary to law, that they can mislead and deceive women into compliance "for their own good".

> *'As a midwife working in hospital, how do I navigate around a consultant obstetrician/registrar telling a woman her baby will 'die' or 'do you want to keep your baby safe' if she doesn't partake in a certain action?'*

To be clear, these systemic practices constitute assault and battery, violate the fundamental human right to bodily autonomy and integrity, the legal right to choose or refuse treatment, the right to privacy and self-determination and, especially in cases of unconsented surgery, constitute cruel and inhumane treatment.

As the Special Rapporteur observed in her *OV Report*:

> Women are frequently denied their right to make informed decisions about the healthcare they receive during childbirth and other reproductive health services; this lack of informed consent constitutes a human rights violation that could be attributed to States and national health systems.[18]

Informed consent is both poorly understood and intentionally denied to pregnant and labouring women through the forced application of routine maternity healthcare practices in Australia, *from the moment a woman engages with an institutional careprovider.*

Over the last 11 years, women have reported careproviders who:

- abuse the doctrine of implied consent;
- enforce the myths of foetal and fathers' rights to violate womens' rights;
- question and reject the legal presumption of competence in relation to pregnant women;
- abuse the doctrine of medical necessity.[19]

A woman lying on the bed *is not and can never be impliedly consenting to a vaginal examination, episiotomy or a careprovider placing their hands inside her vagina, uterus or anus.* Careproviders know and understand this because the majority of women dislike and/or object to

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[18] Simonovic, *OV Report*, n 12.

[19] Šimonović n14, [48-9].

such examinations. From the reports we are receiving, these appear to be done for convenience, with utter disregard for the legal rights of women.

The doctrine of medical necessity is the **only** narrow circumstance where informed consent is not required. It strictly applies where there is a *genuine emergency*, and the woman is either unconscious or found to be incompetent following assessment by two psychiatrists and a declaration sought from a court of law. Even in that instance, careproviders must first ascertain whether a family member or support person has been given the authority by the woman to relay her wishes.

> *I was brought on, drip & waters broken & left alone for almost 5hrs when some1 finally had time & my BP was that high I almost had a stroke. All of a sudden, I had like 3-4ppl in there.*

The reports we received indicate that emergencies are being falsely claimed to conceal incompetence, neglect, limited resources and provider convenience. This is misleading and deceptive conduct, unlawful under Schedule 2, *Competition and Consumer Act 2010* (Cth). Careproviders are also treating women who do not agree with their recommendations as incompetent, and using these unfounded assumptions as a basis for avoiding their legal obligation to obtain informed consent. This too is unlawful. It is the law that all adults are presumed competent unless and until deemed otherwise by two psychiatrists and a court of law.

Women regularly report being left alone or with an inexperienced careprovider and a CTG monitor. Suddenly, and without warning, several careproviders will rush into the room, declare an 'emergency' and impose the need for immediate intervention with little to no explanation other than a claim that the baby's life is at risk. This appears to be recurrent theme amongst women being induced who are not being informed that inductions to augment labour can exhaust the baby and typically lead to unwanted Caesarean Section (**CS**). It is a material risk or consequence of induction which is rarely, if ever, discussed with women. We add that the use of CTG monitors is not evidence based practice and its use has been questioned by researchers, lawyers and medical providers alike.

With each push, Georgia Lilley knows it won't be long until she can cradle her newborn in her arms.

Overcome with another contraction, she's suddenly surrounded by medical staff inside Tasmania's second-largest hospital, Launceston General.

The doctor informs her they are moving on to an instrumental birth, and begins to describe a ventouse birth, also called vacuum, where a suction cup is placed on the baby's head to help guide it out.

Georgia's doctor says if it doesn't work, they will place metal forceps around the baby's head to assist with delivery.

"The thought of forceps terrified me, that was one thing that I thought was archaic," she said.

"I knew I did not want that."

Before Georgia can object, she says they start to attempt a ventouse birth without her consent.

Her screams fill the room as she begs the doctors to stop, but Georgia's pleas go ignored.[20]

What we know often occurs is that the woman is alone but being monitored remotely, without her knowledge, by doctors on standby at the doctor's station. In other words, she is left without support until an alarm warns doctors that the baby is getting tired as a result of the augmentation which is then disguised as an "emergency" and used to impose a number of interventions on the woman without adequate

[20] April McLennan, "Birth rights" *ABC News* (16 June 2024), https://www.abc.net.au/news/2024-06-16/lgh-new-mothers-suffer-abuse-in-hospital/103878882.

information and support.[21] This is particularly a tactic deployed by privately practising medical providers, Visiting Medical Officers and/or Locums who receive remuneration for each intervention and birth that is performed during their shifts. The financial incentives result in practices that do not afford informed consent. Rather, these practitioners are obtaining compliance through the provision of misleading and biased information to suit institutional or personal interests.

> *"...He gave me two options - have a C section that afternoon (this discussion was at 7am so the urgency was clearly not there) or discharge myself against medical advice and seek care elsewhere. I felt bullied, belittled and betrayed by his behaviour. I was backed into a corner to agree to the one outcome I did not wish for - a C section.*
>
> *I had my baby via C section at 3.40pm that day, a Friday. I had a massive panic attack on the operating table and disassociated from the entire event. I cannot remember my baby being born. I feel physically sick when I look at photos that were taken for me. ...My bond with my baby was very negatively impacted ...due to my declining mental health. I could not sleep due to my anxiety and had to be medicated for this. ...*
>
> *My OB later told me he enjoyed his weekend away."*

> *"I asked to try a different position ... Got into that position, then the doctor and other medical staff came in, all the lights went on and they advised me to get on my back as we were going to have to get an emergency caesarean. I cried because I was so upset and tired. I signed the consents although I didn't feel I had*

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[21] Kirsten Small et al 'My Whole Room Went Into Chaos Because of That Thing in the Corner": Unintended Consequences of a central Fetal Monitoring System' (2021) 102 *Midwifery* e103074.

any choice in this matter. ***They asked if the baby dropped once arrived in theatre, would I want to try forceps or vacuum.*** *I agreed to the vacuum. I was taken down to theatre. This was so scary with all the lights and my legs were strapped up in stirrups. They said baby had dropped ("miracle") and baby was born at 2:12am with vacuum and episiotomy not long after. I didn't realise or was told I'd have an episiotomy until afterwards when they advised I was having the episiotomy sewn up. I was absolutely exhausted after this…I cried for weeks after my birth."*

Misleading women during labour and birth appears to be a common occurrence in Tasmania. Despite the objections made by women, we note that absolutely no effort has been made to improve practices.

My OB said 'I can almost guarantee you that you have a subclinical level of infection and that you are risking your baby becoming extremely unwell by delaying any longer' despite the fact I had been on 4 hourly IV antibiotics and had no signs of infection.

The intentional practice of violating human rights during the delivery of health services is a reflection of poor quality care. No amount of costly technology and/or medication can address these practice shortcomings or alleviate the resulting human rights violations.

5. How Tasmania's Medical Liability Laws and Insurance Policies Normalise Obstetric Violence

Human rights violations of pregnant women during the provision of facility based maternity care are so commonplace and normalised, they

are considered best practice by plaintiff medical liability lawyers, insurers, judges, coroners, the police and child support services, each of whom are motivated by interests and perspectives which bear little to no consideration for the implications on women's human rights.

Medical liability and defensive medicine feature heavily in the practice of maternity careproviders. Successful compensation claims turn into insurer's conditions for practice which turn into hospital policies and practice standards that are usually mandated, without any regard for the need for informed consent.[22]

Doctors commonly assert that liability mandates the overuse of interventions in maternity care, the overriding of informed consent and the focus on the fetus as a patient.[23] The reality is somewhat more complex. Tort reforms were introduced in 2002 in Tasmania,[24] which severely curtail consumer rights to redress for certain harms, such as by reintroducing a modified *Bolam Principle,* preventing certain claims for personal injury and death, imposing cost penalties on small claims, restricting claims for psychological harms, and placing caps on damages. Intervention rates in Tasmania and dissatisfaction in care have nevertheless continued to rise. In 2010, 27.4% of women in Tasmania had an induction. In 2022, 1 in 3 (32.6%) of women in Tasmania were deemed incapable of delivering their baby without augmentation or

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[22] Tim Draycott, Rachel Sagar and Susannah Hogg, 'The role of insurers in maternity safety' (2015) 29(8) *Best Practice & Research Clinical Obstetrics & Gynaecology* 1126-1131.

[23] CT Johnson et al, 'Malpractice and obstetric practice: the correlation of malpractice premiums to rates of vaginal and cesarean delivery' (2016) 214(4) (2016/01/16) *Am J Obstet Gynecol* 545-546.

[24] The Hon Justice Ipp, *Review of the Law of Negligence* (Final Report, Cth: Sept 2002).

induction.[25] In just 10 years, Tasmanian Caesarean Section rates have risen from 29.5 to 36.1 percent.[26] The WHO recommendation for an optimal CS rate is between 10-15 percent. Aside from the massive increase in healthcare spending, if there was genuine medical evidence for the claim that 1 in 3 women are incapable of delivering an infant without augmentation, the future of the human species in Tasmania would be in serious doubt. There are clearly other factors at play.

Economic indicators suggest that careprovider perceptions of risk aren't the only factors to drive interventionist and defensive practice.[27] Far more serious matters are at play, such as the adoption of the more restrictive practices of colleagues to boost volume of deliveries and increase throughput, minimise insurance premiums, receive higher reimbursements, and schedule procedures for convenience or profit.[28] While the Committee may consider these an acceptable expression of self-interest (as do we), our concern is that they pose a clear conflict of interest that must be disclosed prior to the provision of care. It is a fact that *women are never apprised of these conflicts of interest before their engagement with any maternity careprovider*, which is in itself a clear violation of the right to informed consent.

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[25] Australian Institute of Health and Welfare (Cth), *Australia's Mothers and Babies* (Web Report, Canberra: 29 June 2023) https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/onset-of-labour.

[26] Australian Institute of Health and Welfare (Cth), *Australia's Mothers and Babies* (Web Report, Canberra: 29 June 2023) https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/method-of-birth.

[27] Cano Urbina J & Montanera D, "Do Tort Reforms Impact the Incidence of Birth by Cesarean Section? A Reassessment." (2017) 17(1) *International journal of health economics and management* 103-122.

[28] Joshua S Gans and Andrew Leigh, 'Born on the First of July: An (Un)natural Experiment in Birth Timing' (2009) 93(1) *Journal of Public Economics* 246-263; Joshua S Gans and Andrew Leigh, 'IZA DP No 6165: Bargaining Over Labor: Do Patients Have Any Power?' (2012) 88(281) *Economic Record* 182-194.

Harms arising from human rights violations, unless associated with deviations from accepted medico-legally endorsed practice, are not recognised[29] and therefore devalued and dismissed as unimportant in medico-legal culture and practice.[30]

This is reinforced by Tasmania's tort laws. Since amendments were introduced into the *Civil Liability Act 2002* (TAS) to cap damages and recoverable costs, particularly in relation to psychological injury, mental health injuries and post-traumatic stress disorders caused by abuse and mistreatment have been dismissed as an insignificant risk by health care facilities and careproviders.

In addition, even if a claim contains both physical and psychological injury, the modified version of the *Bolam Principle* in relation to diagnosis and treatment, reinstated under section 22 of the *Civil Liability Act 2002* (TAS) (CLA), prevents women from seeking justice (**Bolam Defence**). Under these provisions, a careprovider is not negligent if the treatment provided was based on a peer accepted practice. This means that, provided an identifiable group of

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[29] V Tonei, 'Mother's mental health after childbirth: Does the delivery method matter?' (2019) 63 (2018/12/31) *J Health Econ* 182-196.

[30] F Diaz-Tello and B Kumar-Hazard, 'What are Women's Legal Rights When It Comes to Choice in Pregnancy and Childbirth?' in HG Dahlen, B Kumar-Hazard and V Schmied (eds), *Birthing Outside the System: The Canary in the Coalmine* (Routledge, 2020), Chapter 14; A Barrett and AJ Kotaska, 'Obstetricians discuss the Coal mine and the Canary' in H.G Dahlen, B Kumar-Hazard and V. Schmied (eds), *Birthing Outside the System: The Canary in the Coalmine* (Routledge Research in Nursing and Midwifery, 2020) Chapter 20.

careproviders all violate consent to prioritise an unborn infant over the mother, the woman may not have a claim.

The incentive for all providers to practise in a way that violates informed consent is consequently reinforced. For example, a woman may have endured fourth degree perineal tears because an obstetrician performed an episiotomy she did not consent to while performing a forceps delivery. If it can be shown in defence that (a) the woman consented to the forceps delivery and (b) peer accepted practice is to perform both the episiotomy and forceps as part of the same treatment, that careprovider will not be negligent for the fourth degree tears even if it can be shown that the *unwanted episiotomy caused the fourth degree tears*. Following a court ruling to that effect, it will become standard practice to perform an episiotomy without consent when applying forceps as peer accepted practice. In other words, prevailing careprovider practice decides whether or not a woman's human rights are violated. In this way, section 22 of the *Civil Liability Act 2002 (*TAS*)* discriminates against pregnant women, disincentivises improvements in care, and encourages careproviders to violate fundamental human rights with impunity.[31] The act of cutting someone in their genital area without consent, which would normally constitute aggravated assault and battery, becomes a peer-accepted standard of care. We cannot imagine this happening to men with the same degree of impunity.

Medical liability laws and insurance policies also reinforce the myth of fetal rights over the human rights of women. Careproviders are taught, through medical liability laws and insurance policies, to prioritise the infant over the mother, because infants are likely to fetch higher damages awards than mothers.

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[31] A Waytz & J Schroeder 'Overlooking Others: Dehumanisation by Omission and Commission' (2014) 21(3) *TPM*– Special Issue 1-16.

Precedents, caps on damages and the s22 Bolam Defence make maternal injury cases much less attractive to contingency fee lawyers, further reinforcing these inequalities. The contingency fee structure is assumed to provide solutions to access to justice concerns and a means of redress for the most vulnerable and most injured. Unfortunately, it also presents significant access challenges for women. The contingency fee structure's efficacy is predicated on the promise of sufficient returns to both compensate and cover the costs of bringing the case. Contingency fee lawyers will only accept cases in which they expect a significant damages award.

Even if a case makes it to court, precedent findings in medical malpractice cases tend to downgrade maternal injury and prioritise fetal injury. Winning is rare in maternal injury only claims and often justified only because of serious or permanent maternal injury. Consequently, this constitutes a barrier to access to justice that prevents a legal remedy even before courts have had a chance to examine what could be a meritorious claim. The failure to seek redress for such claims reduces incentives for deterring harms, as reflected in abusive facility based practice and culture today.

6. How Courts And Coroners Interpret Laws And Make Findings That Normalise Obstetric Violence

In a society where women hold less intrinsic value, and injuries to the infant are taken more seriously, courts have also relied on the paternalistic 'doctor knows best' approach to dismiss the significance of patient autonomy in maternity care. A perverse result follows; whereas human rights principles emphasise the independence, agency and equality for women, medical malpractice presupposes an ignorant patient, dependent on an expert who was expected to take control of

her care in order to secure an "optimal outcome" informed by the expert's need for self-preservation.

As a result of the way medical liability laws are interpreted and applied, the expert will be found to have breached their duty of care if they did *not* take control of the woman and force treatments the expert believed to be necessary. There is an assumption that the woman does not have any say over what happens to her body.

We have also researched and documented alarming reinforcements of harmful gender stereotypes, over-reliance on the medico-legal framework, support for violations of women's human rights and the elevation of foetal personhood in coronial investigations and findings in relation to women who choose out-of-facility birthing options. These findings give credence to facility and careprovider beliefs that they are legally entitled to infringe human rights and perpetrate obstetric violence in "a woman's best interests".[32]

Time and again in such inquests, evidence of the abuse and mistreatment endured by the women, and the profound impact it had on the physical and mental health of women and babies[33], was presented to and dismissed by the coroner.

Coroners dismiss evidence of abuse and disrespect during childbirth by infantilising women. In Dillon & Hadley's "*Manual for Coroners*", the

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[32] B Kumar-Hazard, 'The role of the coroner in Australia: listen to or ignore the canary?' in H.G Dahlen, B Kumar-Hazard and V. Schmied (eds), *Birthing Outside the System: The Canary in the Coalmine* (Routledge Research in Nursing and Midwifery, 2020) Chapter 14.

[33] S

authors declared their pre-conceived views about women who choose homebirth:

> "Home Birth Issues
>
> The safety of home births is a controversial issue that tends to generate passionate views on both sides of the question. Unfortunately, sometimes, midwives and parents err on the side of "natural birth" when it is unsafe – even obviously unsafe – to do so."[34]

This statement is revelatory. It assumes that women and midwives are, *as a class of persons*, irrational and/or emotionally driven to make unsafe decisions. It also implies that adult competent women are either not able to make decisions for themselves or that adult *pregnant* women are *not competent* to make decisions for themselves. The infantilising of women is discrimination on the basis of sex and pregnancy. It also constitutes a breach of Australia's obligations as a contracting party to CEDAW.

Of course it's a woman's right to choose, but….

The authors did not stop there. They endorsed the unequal treatment of women before the law by relying on to publications to assert the claim that pregnant women owed a moral responsibility to society to endure mistreatment in childbirth in order to prevent injury to the unborn infant.[35] The first publication relied upon was a sensationalist opinion piece from a lifestyle e-magazine ('Mamamia').[36] The second publication is a controversial piece by a conservative "pro-life" ethicist

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[34] H Dillon & M Hadley, *The Australasian Coroner's Manual* (The Federation Press, Leichardt, 2015), 154-155.

[35] Ibid, 155-156.

[36] Mammamia News, "Homebirths killed three babies. It's official" (June 10, 2012) at <https://www.mamamia.com.au/home-birth-killed-three-babies-coroner-says-they-could-have-lived>

and an anti-homebirth obstetrician arguing that to have a homebirth is to automatically harm a fetus, which *should constitute a crime* in Australia (**Savulescu Article**).[37]

Coroner Dillon cited the same two publications in the *Inquest into the death of Bodhi Eastlake-McClure*, and adapted the Savulescu Article's claim to suit, claiming "women and midwives had a moral responsibility to prevent injury to the unborn infant".[38] This was a dangerously biased, ill-informed and surreptitious application of foetal rights. The Coroner chose to ignore the obvious flaws in the Savulescu Article, as highlighted by Professor Hugh Lachlan:

> Their conclusion is highly debatable on two grounds. It is not clear that home deliveries are riskier than hospital ones. Even if they are riskier, it doesn't follow that it is morally wrong for women to choose to have them.
>
> …There might also be particular risks associated with hospital deliveries. For instance, mothers and babies might be more exposed to infectious diseases there. They could also run the risk of injury or death in a road accident on their journey to and from the hospital. These risks are slight but so too are the risks of disability that Crespigny and Savalescu talk of. It is not clear that it is irrational for a woman to choose to have a baby at home rather than a hospital. **It isn't possible to avoid risk if one chooses to have a baby. And it isn't obvious that one could possibly know that, all things considered, one choice was riskier than the other.**[39] (Emphasis added)

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[37] J Savulescu & L de Crespigny, "Should it be a crime to harm an unborn child" (2014) The Conversation (21 Mar), https://theconversation.com/should-it-be-a-crime-to-harm-an-unborn-child-24407

[38] H Dillon, Inquest *into the death of Bodhi Eastlake-McClure* (2014) *State Coroner's Court of New South Wales, Glebe,* [77-8].

[39] Hugh Lachlan, "There is no moral imperative for women to give birth in hospital" (2014) *The Conversation* (8 Feb, The Conversation Media Grp, 1.32am AEDT) <

7. How Tasmanian Child Protection Laws Facilitate Obstetric Violence

We regularly advise women who inform us that their GP or the local hospital has notified them to Child Services because they have refused a particular medical treatment.

> *I wanted to take my baby to the CHaPS nurse when he was 12 weeks old, for a general well-being check-up. When I arrived at the service the nurse advised me that someone at the service had reported me to Strong Families Safe Kids, because I had told the booking in receptionist that I had free birthed my baby.*
>
> *This was incredibly distressing to hear. As soon as I got home, I cancelled all other appointments with the CHaPS service and decided to only seek GP care.*
>
> *We now feel like we have a 'mark' against our name. We felt anxious taking our kids out in public, we were scared that people thought we were negligent parents.*

To be absolutely clear, there are no laws prohibiting a woman from choosing the circumstances of her birth, even if they are deemed unacceptable by careproviders or law enforcement. To impose such obligations on women would be to breach Australia's fundamental obligations as a signatory to CEDAW.

Section 13 (1)A of the *Children, Young Persons and Their Families Act 1997* (Tas) (the **Act**) provides that a person who has reasonable grounds to know, suspect or believe, before the birth of a child, that the child may be at risk of significant harm or neglect after his or her birth *must* make a report to Strong Families Safe Kids.

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https://theconversation.com/there-is-no-moral-imperative-for-women-to-give-birth-in-hospital-22732>.

An unborn fetus is not a person or a child under the *Children, Young Persons and Their Families Act 1997* (Tas). It is questionable as to whether section 13(1)A of this Act is consistent with the principle of equality before the law as enshrined in the Australian Constitution. It is also likely that the mandatory reporting of adult pregnant women who have the legal and human right to choose or refuse care is inconsistent with the *Sex Discrimination Act 1984* (Cth).

To enliven the pre-natal reporting powers under section 13(1)A of the Act, the reporter must have (a) *reasonable grounds* to suspect (b) risk of ***significant*** *harm or neglect* (c) to the child ***after*** *the birth*. Strong Families Safe Kids will be acting beyond its statutory powers by threatening and attempting to control pregnant women who choose or refuse medical care. Careproviders are making pre-natal reports against women in circumstances where they could not possibly have formed reasonable grounds to suspect that the infant is at risk of significant harm *after the birth* because the infant does not yet exist. There are no reasonable grounds for assuming that an adult competent woman who declines medical treatment before the birth is going to put her child at risk of significant harm after the birth. The words "after the birth" are not, in their natural and ordinary meaning, the same as "during the birth" or "as a result of the birth". The way in which s13(1)A is being interpreted by the Department and careproviders highlights their mutual belief in the harmful gender stereotype of "the good mother". The good (prospective) mother will sacrifice her physical and mental wellbeing for her child or she likely does not deserve to be a mother at all.

Aside from biased, discriminatory statutory interpretations, we note the following:

- even if a careprovider believes the woman should have a treatment, they are not entitled to force that decision on the woman. Most of the submissions we received show instances of significant therapeutic incompetence. We need to remember that careproviders can, and regularly do, get things wrong. Careproviders may also, like everyone else, be driven by harmful gender stereotypes about women and believe that they are entitled to control and coerce women. These beliefs and interests cannot and should not form the basis for reasonable grounds to suspect significant harm; and
- while section 13(1)A of the Act gives Child Services the authority to receive a pre-natal report, it does not give the Child Services Department the authority to coerce pregnant women into enduring medical treatments.

Administrative bodies are required, under the stewardship of government, to ensure that their actions do not infringe the human and legal rights of women. The Child Services Department is obliged, as an administrative body acting on behalf of the government, to ensure that it does not violate the human rights of pregnant women. If it is receiving and documenting reports against pregnant women, it is misusing its very limited remit under s13(1)A to threaten and coerce pregnant women on behalf of facilities and GPs into accepting treatments they do not want. Section 13(1)A is a violation of the human rights to bodily autonomy, equality, privacy, self-determination, protection of the family as a fundamental unit of society and to be free from discrimination, and degrading or inhumane treatment.

8. How Maternity Careproviders Have Deployed These Regulatory And Institutional Protections To Engage In Obstetric Violence

The medical profession has never been afforded any consent training and have little to no understanding of the human and legal rights of pregnant women. This is not due to any fault of current obstetricians. Obstetrically driven maternity care was not initiated or developed through a human rights lens. It was informed by racism, coercion, slavery, misogyny and financial gain.[40] These beliefs endure.[41]

What is important to women is not what used to be, but the apparent refusal by maternity careproviders to acknowledge these foundations in order to change, and to adapt to a society where women have fundamental rights to equality, dignity and freedom from harm.

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[40] Irvine Loudon "General Practitioners and Obstetrics: A Brief History" (2008) 101(11) *Journal of the Royal Society of Medicine* 531-535; Ben Stanley, "History, Race, Time, and the Father of Gynecology" (7 July 2021) *Online Medical Education* < https://www.onlinemeded.com/blog/as-no-man-had-seen-before-history-race-time-and-the-father-of-gynecology>; Brynn Holland, "The 'Father of Modern Gynecology' Performed Shocking Experiments on Enslaved Women" (2018) *History* < https://www.history.com/news/the-father-of-modern-gynecology-performed-shocking-experiments-on-slaves>; D Ojanuga, "The Medical Ethics of the 'Father of Gynaecology', Dr J Marion Sims" 19(2) *Health Social Work* 120-124.

[41] Nadia von Benzon, "My Doctor Just Called Me A Good Girl And I Died A Bit Inside': From Everyday Misogyny to Obstetric Violence in UK Fertility and Maternity Services" 334 *Social Science & Medicine* 116614; Kelly M Hoffman, S Trawalter, JR Axt, MN Oliver, Racial Bias in Pain Assessment and Treatment Recommendations, and false Beliefs About Biological Differences Between Blacks And Whites, 113(16) *Proc. Natl. Acad. Sci. U.S.A* 4296-4301; Assoc Prof Ruth Phillips, "Comment: Obstetric Violence: The Threat Facing Women in the Delivery Room" *Body and Soul* (19 April 2019) https://www.bodyandsoul.com.au/health/womens-health/obstetrics-violence-the-threat-facing-women-in-the-delivery-room/news-story/cfbbf55c5b500941999b6f40f7a81ee0.

In our experience, and this is not limited to Tasmania, medical careproviders have been openly resistant to a change in practices which would respect the dignity and equality of pregnant women – even "low hanging fruit" such as the need for consent before performing a vaginal examination. We are regularly 'told' (based purely on the opinion of the careprovider) that the unborn fetus and fathers have equal rights over the woman's body. This is an intentional disregard for the legal and human rights of pregnant women. Most are blind to standardised processes which dehumanise pregnant women and therefore resist change. In Queensland and Western Australia, where governments have mandated the human rights and mental health training we provide, we have been attacked, vilified, dismissed and even boycotted. These actions appear to be endorsed by the lead professional organisations. We have seen Whatsapp messages of providers looking for ways to exempt themselves from such training and complaining about how stupid, selfish and self-entitled women have become.

No other profession has the social legitimacy, in spite of its role as a profit-making service provider, to publicly and morally censure, control and coerce women, and apply harmful gender stereotypes with impunity and with legislative and judicial endorsement. Members of the profession feel confident and secure enough to speak on behalf of women, openly and publicly attack anyone who makes health choices they do not approve of, question women's legal right to the presumption of competence, mislead and deceive women during episodes of care to coerce compliance, ignore their legal obligation to obtain informed consent, dismiss consumer concerns about mistreatment, reframe social debate around human rights and risk, and publicly disparage their competitors. This is the power that medical professionals wield outside, and carry into, the birth room. In that birth room, a labouring woman supported only by a partner who knows even

less than her, simply does not stand a chance. Practices that take advantage of this power imbalance constitute abuse and mistreatment.

a) Developing Policies And Procedures That Violate Women's Human Rights

Careproviders are often quick to blame limited or declining resources as the reasons for abusive and disrespectful treatment. There is some support for this but, in maternity care, it is not necessarily about resources *per se*. It is more about *resource allocation.* A significant amount of money and resources is dedicated to acquiring technology and medicines, alongside limited investment in high quality midwifery personnel. These spending decisions are being made by hospital directors who do not see, or care for, the intrinsic value that continuity of midwifery maternity care provides, particularly from the perspective of women.

As we know, a significant portion of the already high national healthcare budget is dedicated to funding institutional maternity health services and careproviders. Through an overemphasis on technology and medical processes at the expense of personalised care, institutional maternity healthcare has become a highly standardised, process driven, fragmented and dehumanising model of care that produces and sustains a culture of abuse and disrespect for which women are told every day to be grateful.

Women fortunate enough to access continuity of midwifery-led care such as through MGPs and birth centres consistently cite high levels of satisfaction with their care and strong relationships with supportive, responsive and accountable careproviders. Yet, resources dedicated to such services are manifestly inadequate and are, in any event, strongly resisted by medical practitioners.

Women in Tasmania report being put through an assembly line[42], referred to by institutions as "care pathways", which promote forcing the birth process and replacing interpersonal care with technology and routine medical treatments. [43] Care pathways are informed by policies and procedures which dehumanise women. Hospital guidelines, policies and protocols are written in ways that mandate routine interventions and invasive procedures during labour and birth, with no regard for the woman's preferences and/or right to give informed consent, including:

- Repeat vaginal examinations every 4 hours, following a change of shift, whenever there is disagreement between careproviders or just because the obstetrician does not believe the midwife[44];
- Anal examinations without consent;
- Electronic Fetal Monitoring without consent[45];
- Blood tests for drug and alcohol screening;

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[42] M Hansson et al, 'Veiled Midwifery in The Baby Factory - A Grounded Theory Study' (2019) 32(1) (2018/05/02) *Women Birth* 80-86

[43] D Walsh, 'Subverting the Assembly-Line: Childbirth in a Free-Standing Birth Centre' (2006) 62(6) *Soc Sci Med* 1330-40.

[44] S *Cohen* Shabot, 'Why 'Normal' Feels So Bad: Violence and Vaginal Examinations During Labour – a (Feminist) Phenomenology' (2021) 22(3) *Feminist Theory* 443–463; Rebecca Brione, 'Non-Consented Vaginal Examinations: The Birthrights and AIMS Perspective' in Camilla Pickles and J Herring (eds), *Women's Birthing Bodies and the Law : Unauthorised Intimate Examinations, Power and Vulnerability* (Hart Publishing, 1st Ed, 2020).

[45] Kirsten Small et al 'My Whole Room Went Into Chaos Because of That Thing in the Corner": Unintended Consequences of a central Fetal Monitoring System' (2021) 102 *Midwifery* e103074; Kirsten A Small et al, '"I'm Not Doing What I Should Be Doing as a Midwife": An Ethnographic Exploration of Central Fetal Monitoring and Perceptions of Clinical Safety' (2022) 35(2) *Women and Bi*rth 193-200; KA Small et al, 'Midwives Must, Obstetricians May: An Ethnographic Exploration of How Policy Documents Organise Intrapartum Fetal Monitoring Practice (2022) 35(2) *Women Birth* e188-e197; KA Small et al, 'The Social Organisation of Decision-Making About Intrapartum Fetal Monitoring: An Institutional Ethnography' (2023) 36(3) *Women Birth* 281-289.

- Screening for diabetes and BMI[46];
- Prophylactic antibiotics[47];
- Pitocin induction of labour[48];
- Episiotomies[49];
- Placing women in the supine position to labour for the convenience of the careprovider[50];
- Strict observation of reduced (and undisclosed) time limits for stages of labour and induction of labour;
- Expedited cord-clamping and cutting[51];
- Denying mother and baby skin to skin contact immediately after or in the first few hours of birth (this is a particular problem in privately funded facilities where women who have had CSs are not informed that they may be separated from their infants for at least 2 hours

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[46] Rae Thomas, Clair Heal & Julia Lowe, 'Are You at Risk of Being Diagnosed with Gestational Diabetes? It Depends on Where You Live' *The Conversation* (The Conversation Media Group, 6 Mar 2019) <https://theconversation.com/are-you-at-risk-of-being-diagnosed-with-gestational-diabetes-it-depends-on-where-you-live-112515>.

[47] T Tapiainen et al, 'Impact of intrapartum and postnatal antibiotics on the gut microbiome and emergence of antimicrobial resistance in infants' (2019) 9(1) *Scientific Reports* 10635; M Reyman et al, 'Impact of delivery mode-associated gut microbiota dynamics on health in the first year of life' (2019) 10(1) Nature Communications 4997.

[48] DHE Hargreaves, 'Induction of Labour in Nulliparous Women at Term: Factors influencing a High Caesarean Section Rate' (2018) 58(1) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 3-25.

[49] C Clesse et al, 'Statistical trends of episiotomy around the world: Comparative systematic review of changing practices' (2018) 39(6) *Health Care for Women International* 644-662.

[50] HG Dahlen et al, 'From social to surgical: historical perspectives on perineal care during labour and birth' (2011) 24(3) *Women Birth* 105-11; A De Jonge, TAM Teunissen and ALM Lagro-Janssen, 'Supine position compared to other positions during the second stage of labor: A meta-analytic review of Birthing positions' (2004) 25 *Journal of Psychosomatic Obstetrics & Gynecology* 35–45.

[51] H Rabe et al, 'Effect of timing of umbilical cord clamping and other strategies to influence placental transfusion at preterm birth on maternal and infant outcomes' (2019) 9(9) *Cochrane Database Syst Rev*. CD003248.

after the surgery, which contributes to significant problems with breastfeeding)[52];

- Blanket VBAC bans[53], twin vaginal delivery bans and breech vaginal delivery bans.[54]

The Department of Health and regulators expect staff to comply with policies and guidelines above all else, even where the result is to violate women's human rights. Careproviders who seek to respect women's autonomy are placed in a difficult position[55]: violate a woman's human rights or face disciplinary action at work.[56]

Policies and procedures are, in reality, a means to reduce liability risks associated with staff shortages, fragmented care, incompetence,

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[52] J Stevens et al, 'Immediate or early skin-to-skin contact after a Caesarean section: a review of the literature' (2014) 10(4) *Matern Child Nutr.* 456-73.

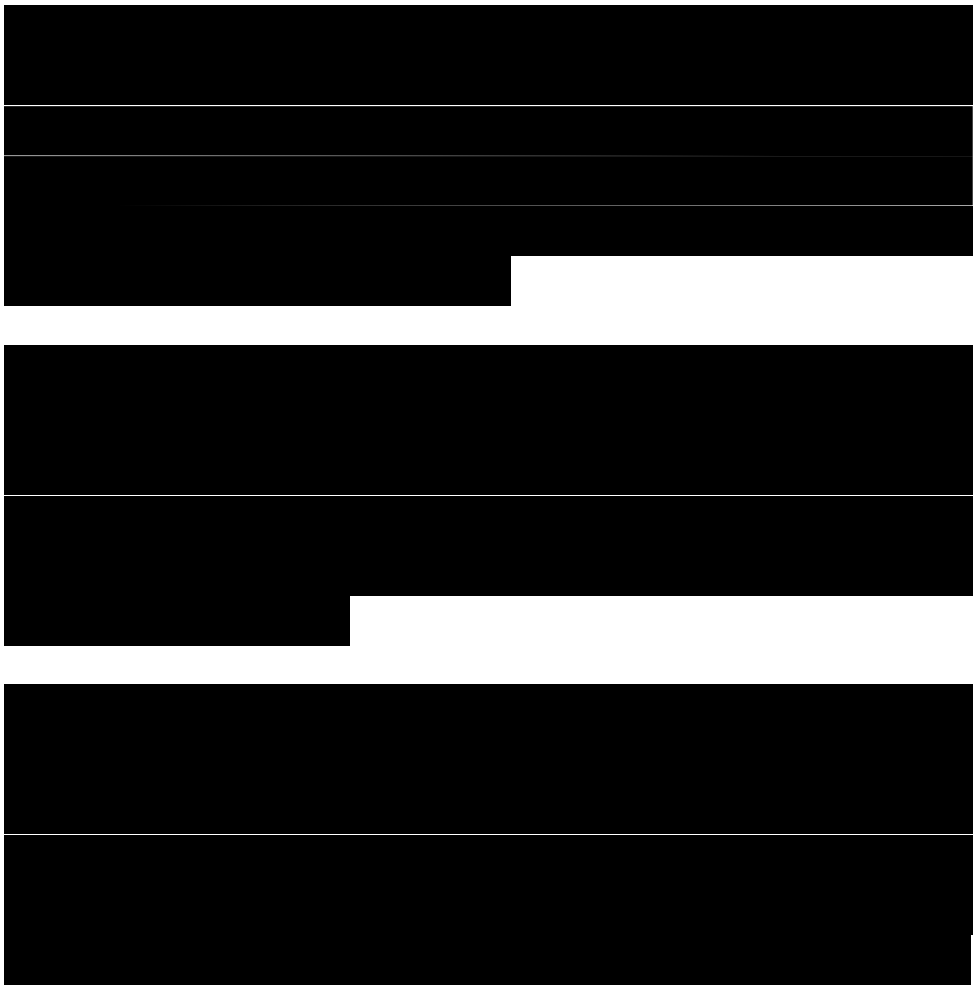
[53] H Keedle et al, 'Women's reasons for, and experiences of, choosing a homebirth following a caesarean section' (2015) 15 *BMC Pregnancy Childbirth* 206; H Keedle et al, 'From coercion to respectful care: women's interactions with health care providers when planning a VBAC' (2022) 22(1) *BMC Pregnancy Childbirth* 70; I Lundgren et al, 'Clinicians' views of factors of importance for improving the rate of VBAC (vaginal birth after caesarean section): a qualitative study from countries with high VBAC rates' (2015) 15 *BMC Pregnancy Childbirth* 196.

[54] CSE Homer et al, 'Women's experiences of planning a vaginal breech birth in Australia' (2015) 15(1) *BMC Pregnancy and Childbirth;* A Bisits, 'Risk in obstetrics - Perspectives and reflections' (2016) 38 *Midwifery* 12-3; A Kotaska, 'In the literature: combating coercion: breech birth, parturient choice, and the evolution of evidence-based maternity care' (2007) 34(2) *Birth* 176-180; A Kotaska, 'Inappropriate use of randomised trials to evaluate complex phenomena: case study of vaginal breech delivery' (2004) 329(7473) *BMJ* 1039-42.

[55] K Harvie, M Sidebotham and J Fenwick, 'Australian Midwives' Intentions to Leave the Profession and the Reasons Why' (2019) 32(6) (2019/01/13) *Women Birth* e584-e593.

[56] Elaine Jefford, Julie Jomeen and Margie Wallin, 'Midwifery Abdication – Is It Acknowledged or Discussed Within the Midwifery Literature: An Integrative Review' (2018) 2 *European Journal of Midwifery* 6; GB Kruger and TV McCann, 'Challenges to Midwives' Scope of Practice in Providing Women's Birthing Care in an Australian Hospital Setting: A Grounded Theory Study' (2018) 18 (2018/11/14) *Sex Reprod Health* 37-42; DL Davis and CS Homer, 'Birthplace as the Midwife's Work Place: How Does Place of Birth Impact on Midwives?' (2016) 29(5) (2016/10/25) *Women Birth* 407-415; Kerreen Reiger, 'The Politics of Midwifery in Australia: Tensions, Debates and Opportunities' [53] (2014) 10(1) *Annual Review of Health Social Science* 53-64.

limited supervision of inexperienced staff, and cost cutting. Routine practices both dehumanise women and justify abuse and disrespect.



This is likely why routine policies and practices are rarely, if ever, disclosed to women prior to their attendance at a hospital. Most women are unaware that such policies even exist or that they have been placed in a "care pathway" (which we refer to as the hospital's birthplan), which has already pre-determined the type of care and the number of interventions a woman will receive from the moment she

engages with the facility.[57] Women who ask questions or inquire about developing a birth plan with their careproviders are met with a common evasive refrain, i.e. "we'll have to wait and see what happens because birth is so unpredictable". One would have thought that, in the event of such uncertainty, it is always preferable to have a discussion that develops into a plan that can be adapted to changed circumstances.

In our experience, careproviders are evasive because they have already made their own birthplans (which they refer to as "care pathways") which they are reluctant to discuss with women, arguably with the knowledge that the woman will be easier to control if she does not know what is or will be happening to her. This is blatantly obvious from the submissions we received. Despite obvious violations of the law and human rights, this practice is near universal in Australia. As a retiring practitioner informed us:

> *If we told women what we actually do to them, they would not come here.*

To be clear, hospital protocols cannot trump the fundamental human rights of any person. In addition to being a violation of women's fundamental human rights, the failure to disclose routine processes prior to the engagement of a service is a breach of the consumer protection provisions in Australia.

b) Reinforcing Harmful Gender Stereotypes in Practice

Harmful gender stereotyping stems from strong religious, social and cultural beliefs and ideas about sexuality, pregnancy and

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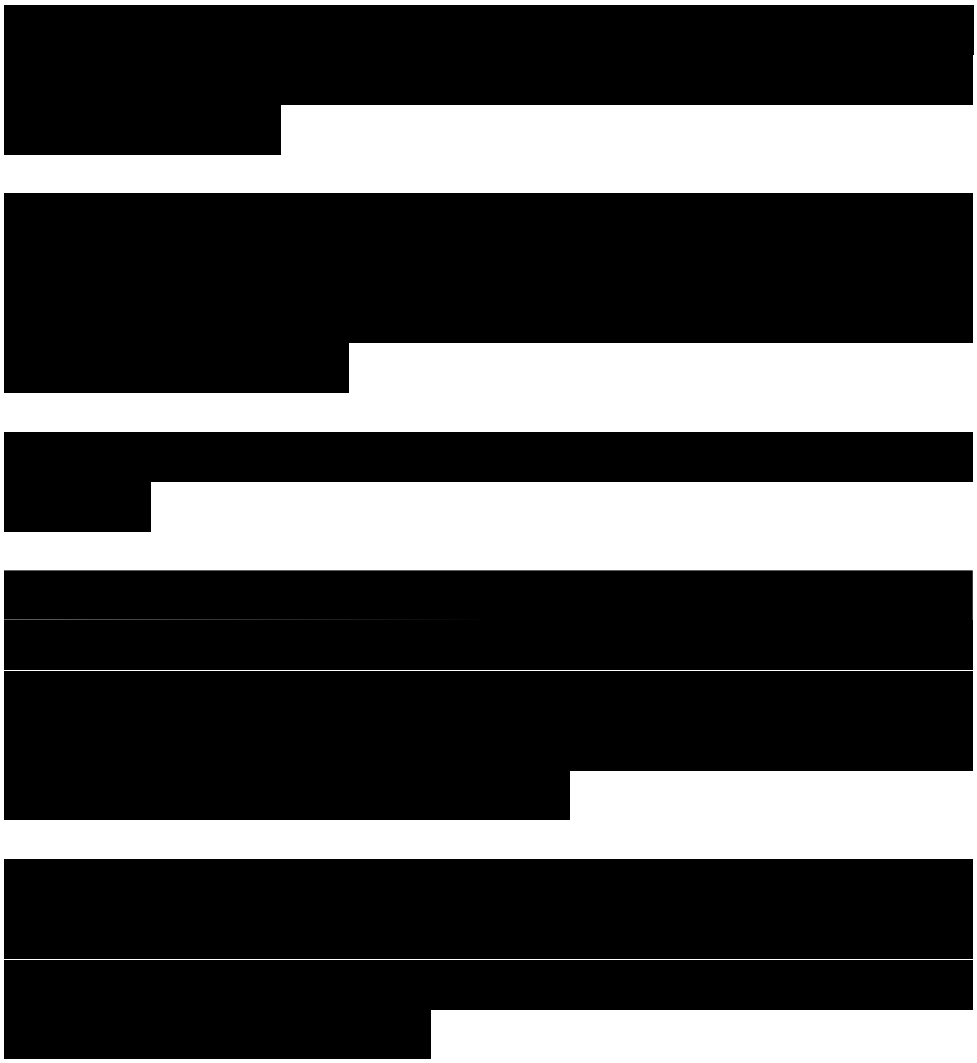
[57] R Thompson R & YD Miller, "Birth control: to what extent do women report being informed and involved in decisions about pregnancy and birth procedures?" (2014) 14 *BMC Pregnancy and Childbirth* 62.

motherhood.[58] Even in the broader social context, Australia has struggled to address violence against women and girls, particularly in relation to domestic violence, sexual assault, sexual harassment and child sexual abuse. The perpetrators of these crimes have one thing in common – they do not respect a woman's right to consent, refuse or decide what happens to her body. It is important to remember that our healthcare facilities are made up of members of the same society. They are not and should not be unimpeachable simply because they are healthcare providers.



[58] International Federation of Gynecology and Obstetrics, *Ethical Issues in Obstetrics and Gynecology: Harmful Stereotyping of Women in Health Care* (London, 2012),), 28.

In this context, courts and coronial findings which 'lecture'[59] adult women for failing to show gratitude for the "life-saving" abusive treatment they received reinforce the harmful gender stereotype careproviders already hold that women should suffer in childbirth.[60] It tells careproviders that obstetric violence, which includes treating women as a means to end (i.e. extracting a live, intact baby at any cost) is best practice, that women are ungrateful if they focus instead on how they were treated, and that good mothers should endure immense suffering as a form of sacrifice:

"Just be grateful your baby is safe and focus on that"

Such gender stereotypes justify abuse and mistreatment, and remove any incentive for institutions to improve on quality or delivery of care. It is discriminatory and disrespectful to lecture women into accepting substandard care that is a form of gender based violence. It would be unthinkable to lecture men in the same way. It is not a stretch to say that any attempt to do so would likely be a news feature within a matter of minutes.

Women who speak up about mistreatment are told that they are very lucky to be giving birth in one of the safest countries in the world and that they should be grateful for their healthy baby.[61]

> ...as one of the most extreme proponents of home births, Joyous Birth has been influential in persuading pregnant women to shun medical

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[59] Schapel, *Inquest into the deaths of Tate Spencer-Koch, Jahli Hobbs and Tully Kavanagh:* File Number 17/2010 (0984/2007, 0703/2009) & 45/2011 (1628/2011) Coroners Courts of SA, (2012), Deputy State Coroner E Schapel, [10.5]; [10.26]; [10.46].; Mitchell, *Inquest into the Death of Roisin Frazer:* File No 0817/2009 (28 June 2012) NSW Coroners Court (Deputy State Coroner Mitchell), [29-31]; Parkinson, Inquest into the Death of Joseph Thurgood-Gates (COR 2010 04851) (2013), Coroners Court Victoria, Coroner Parkinson, [22].

[60] Šimonović n14, [42].

[61] Šimonović n 14, [46].

> intervention in childbirth. It describes as 'birth rape' doctor intervention that saves the lives of mothers and babies...[62]

The belief that women must sacrifice everything, including their physical and psychological to be accepted as good mothers is a harmful gender stereotype observed in countries rich and poor.

"At least you have a healthy baby"

Note that this common refrain does not deny the pain and suffering the woman has endured during labour and birth. On the contrary, using the words "At least" at the start of the sentence is an admission that what happened was traumatic for the woman but, in the larger scheme of things, the message is clear: the woman's own physical and emotional health is no longer valued.[63] In reality, women do not *end up* with a health baby. Babies suffer when mothers sustain injuries and the mental health impact of a broken or damaged parental bond is a problem felt for life.[64]

Diminishing the pain and suffering of women at the hands of careproviders is obstetric violence.[65] It is no different to blaming women who are sexually assaulted. The majority of women do not know what they are going to face when they enter a maternity ward and, as noted earlier, there is a reluctance to provide them with that information. It is

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[62] M Devine, 'Homebirth is Not a Safe Birth', *The Sydney Morning Herald* (online, 9 April 2009) <https://www.smh.com.au/lifestyle/a-home-birth-is-not-a-safe-birth-20090408-a0s3.html>.

[63] Rebecca J Cook and Simone Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (Philadelphia, University of Pennsylvania Press, 2010), 34.

[64] Sofie Van Siegelhem, "Childbirth Related PTSD and Its Association with Infant Outcomes: A Systematic Review" (2022) 174 *Early Human Development*" e105667.

[65] S Cohen Shabot, 'Amigas, Sisters! We're Being Gaslighted: Obstetric Violence and Epistemic Injustice' in Camilla Pickles and Johnathan Herring (eds), *Childbirth, Vulnerability and the Law: Exploring Issues of Violence and Control* (Routledge, 2020).

not and can never be a woman's fault that she endures abuse at the hands of someone she trusts.

Some health services will blatantly deny having abused or disrespected a woman and make her question herself, even where she is obviously in distress and even in the face of profound medical and psychological injuries. Some will tell her that it was for her own good. Others will ignore her complaints. A small portion will send her a standard form, conditional apology, such as "We are sorry that *you think* that we behaved in a way that upset you…".

The hundreds of women we have spoken with could not *all* be mistaken about the mistreatment they experience at a facility, in some cases, at the hands of a protected repeat offender.

We would add just one exception: if the woman, in particular the infant has sustained a physical injury that could interest a medical liability lawyer, the facility will go to some lengths to meet with and apologise to the family. Anything less than an actionable claim for damages, however, is dismissed or ignored.

c) Developing Education And Training Which Undermines Women's Human Rights

Harmful gender stereotypes are reflected in the education and training given to maternity careproviders.

Obstetric medical practitioners have a profound misunderstanding of their role as careproviders of adult pregnant women.

'As doctors, we must constantly advocate for the best interests of our patients, including babies who cannot speak for themselves'

This statement, published by obstetricians in leadership positions in the leading Australian peer-reviewed obstetric journal, is premised on two erroneous claims. The first claim is that the woman and unborn fetus have equal rights in law and practice. They do not. The law is clear – an unborn fetus does not have a separate legal entity from its mother and therefore has no rights before it is born alive and physically separated from its mother. [66] The second erroneous claim is that the doctor can presume to speak for a woman's unborn infant. This too is contrary to the law. A careprovider who presumes to speak for the unborn infant has made a deliberate decision to downgrade a pregnant woman to the status of a second class citizen – i.e. one that can be enslaved to protect the interests of another, at the practitioner's discretion.[67] Not only are these claims false, they are also inconsistent with the recognition and/or protection of women's fundamental human rights. [68]

It is important to note that a decision to alter the legal status of any adult, pregnant or otherwise, is a matter for parliament because it affects women's right to equality before the law. It is likely to require constitutional reform. Either way, it is clearly not, *under any circumstances*,

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[66] United Nations Human Rights Committee, *General Comment No 36: Article 6 re Right to Life*, HRI/GEN/1/Rev.9 (Vol 1), CCPR/C/GC/36, 124 sess, 1834 mtg, UN Doc GE.19-15012(E) (3 Sept 2019) annex 1915012 ('*General Comment No 36: Article 6 re Right to Life*').

[67] D Johnsen "The Creation of Foetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection" (1986) 95 *Yale Law Journal* 599.

[68] UN Human Rights Council, *Report of the Working Group on the Issue of Discrimination against Women In Law and in Practice*, A/HRC/32/44, UN General Assembly 32 sess, UN Doc GE.16-05771(E) (8 Apr 2016), [86].

within the purview of healthcare providers at any stage in the episode of maternity care.

These practices are nevertheless embedded in medical education and facility based training in obstetrics and maternity health care. They are based on a medico-legal fiction coined as "The Obstetric Dilemma"[69] i.e. the belief that pregnancy is an abnormal condition during which the needs of the mother conflict with the needs of her unborn infant.[70] As noted above, underpinning this medical construct is the belief that an unborn fetus has the same legal and human rights that either compete with and/or override the pregnant woman's rights.

As one philosopher argues, however, there appears to be a purpose to maintaining this medico-legal fiction:

> "Broadly speaking, if the unborn child is accorded little or no legal personality, then considerations of maternal autonomy almost invariably trump foetal autonomy. To the extent that the unborn child is accorded substantive legal personality then the road is open to a balancing of foetal autonomy and maternal autonomy that may, in concrete circumstances, result in the prioritising of one over the other."[71]

In reality, the conflict is not between the woman and her infant, but between the woman and the careprovider who is using a fictitious second patient to pursue the careprovider's undisclosed self-interests.[72]

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[69] S McLean & K Petersen, "Patient Status: The Foetus and the Pregnant Woman" [1996] 2(2) *Australian Journal of Human Rights* 229.

[70] Julie Jomeen and Lura L. Pethtel, *Choice, Control and Contemporary Childbirth* (Routledge, Ist ed, 2011). at 16-18.

[71] G Casey "Pregnant Woman and Unborn Child: Legal Adversaries?" (2002) Vol 8 (2) *Medico-Legal Journal of Ireland* 75.

[72] Martine Hollander & Jeroen van Dillen, 'Women Refusing Standard Obstetric Care: Maternal Fetal Conflict or Doctorpatient Conflict?' (2016) 3(2) *Journal of Pregnancy and Child Health* 1-4.

Pitting the interests of mothers against the interests of their unborn infants during the provision of care, whether for religious or financial interests, or liability concerns, has undeniably exacerbated the abuse and mistreatment that women experience in pregnancy and childbirth at the hands of providers who believe that they "speak for the baby".

We ask the Committee to also consider the implications of careproviders overriding women's rights in the presence of spouses and family members who may already be perpetrating violence against that woman. To so brazenly and publicly commit such violence – whether intentional or otherwise – is to effectively give perpetrators of family violence a license to behave as they do.

d) Engaging In A Culture Of Publicly Disparaging Pregnant Women

What has especially emerged from the legal and cultural impunity afforded to careproviders engaging in obstetric violence is the practice of vilifying women for the choices they make in childbirth, even after they have lost a child. Male doctors are frequently asked by conservative extremist media pundits and/or pro-life religious representatives to be the authoritative voice on women's choices over their bodies or preferred medical treatments. The responses they give, in this day and age, have been disappointing to say the least. These are just some of the statements we have seen in news reports:

> 'These women, these couples are not stupid, they are selfish', said WA Australian Medical Association President and obstetrician Dr Michael Gannon.[73]
>
> Australian Medical Association WA president Dave Mountain said there should be [criminal prosecutions] to encompass the 'wild extremes' of homebirths, foetal alcohol syndrome and unborn babies affected by their mothers' drug use.[74]
>
> As a Wodonga obstetrician, Dr Pieter Mourik, says, the natural birth lobby 'has been advocating dangerous practices and I believe the media has a responsibility to publish these cases when a totally avoidable baby death occurs … so *gullible*, pregnant women are not persuaded to follow these risky practices'.[75]
>
> But sadly the minority who choose to be different seem to never accept the blame for their ridiculous decisions when things go wrong.[76]

Abusing and disrespecting pregnant women has been fair game in Australia. According to these statements, women are selfish, ungrateful, gullible, ridiculous, irresponsible and extreme, and they should be subject to criminal prosecutions for harming themselves, and publicly vilified for their personal preferences.

We are not aware of any such extraordinary public attacks on men. Such statements devalue the status of women to little more than reproductive vessels that need to be controlled. Careproviders

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[73] Laura Gartry and Belinda Arrow, 'Women Ignoring Medical Advice on Homebirth 'Selfish': Peak Medical Body Says', *ABC News* (online, 18 June 2015) <http://www.abc.net.au/news/2015-06-18/women-choosing-homebirths-selfish-peak-medical-groups-says/6555662>.

[74] K Campbell, 'Charge Reckless Mums: Doctors' Union', *The West Australian* (online, 27 February 2012) <https://thewest.com.au/news/wa/charge-reckless-mums-doctors-union-ng-ya-328979>.

[75] Ibid.

[76] K Katsambanis, 'Karalee Katsambanis: Home Birth will Always Be a Game of Russian Roulette', *The Sydney Morning Herald* (online, 14 April 2016) <https://www.smh.com.au/opinion/karalee-katsambanis-home-birth-will-always-be-a-game-of-russian-roulette-20160403-gnx6wi.html>.

understand that such sensationalised statements are likely to make the front page of the news and it serves a purpose – to receive social endorsement for the control and coercion that pregnant and birthing women face in maternity wards every day.

Such public statements belie claims by medical providers that they respect women's choices and are adequately trained to afford informed consent.

If that were the case, women would not be sedated against their express wishes or knowledge at facilities in Tasmania:

Launceston General: As a solution to her distress, Holly said she was offered an antidepressant medication, which she declined. "When I woke up, I felt like I'd been spiked. I said, 'Oh, they've given me a tablet when they gave me my needle, but I don't know what they gave me. [My mother] actually pressed the buzzer because she was a bit concerned. And they [hospital staff] came in and said, 'Yeah, we gave her antidepressants because she was upset and crying.'"

The ABC has spoken with other mothers who claim they were also given medication without their consent in the maternity ward of the LGH.[77]

In my labour, I was given a shot of morphine and I did not ask for this nor did I give consent prior. The midwife came into the room and told me she was giving me a shot of morphine.

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[77] April McLennan, "Birth rights" ABC News (16 June 2024), https://www.abc.net.au/news/2024-06-16/lgh-new-mothers-suffer-abuse-in-hospital/103878882.

e) Attacking Women's Right To Choose Their Careprovider

Women have reported:

- Being abused, disparaged and/or refused when they ask their GPs for a referral to a PPM. This can constitute anti-competitive behaviour prohibited by the *Competition and Consumer Act 2010* (Cth) since a referral refusal denies women the right to Medicare reimbursements for PPM care;
- On transfer to hospital:
  - facing abuse and disrespect on arrival for 'inconveniencing' the facility;
  - being told to 'wait their turn';
  - face abuse and criticism from ambulance personnel; and
  - being made to endure **tests and diagnostics without consent** so hospitals can collect evidence to report their PPMs to Ahpra;

Women who are distressed to learn that their PPMs were reported to Ahpra following a transfer to hospital will often seek our assistance to put forward their perspectives to Ahpra. Their submissions are usually ignored.

Hospital staff reactions to the presence of PPMs are nothing short of strange. There is no respect for or recognition that PPMs do not have to replicate the coercive or routine practices deployed by institutions. The very substance of PPM practice, and the qualitative addition to their service offerings, is the fact that care is individualised, autonomy is respected, birth plans are developed with the woman and the woman is treated like an adult who is capable of making her own decisions.[78] It is not in the place of hospital personnel to dictate how a PPM should practice. In our experience, hospital complaints about PPMs nearly

[78] D Fox, A Sheehan and C Homer, 'Birthplace in Australia: Processes and interactions during the intrapartum transfer of women from planned homebirth to hospital' (2018) 57 *Midwifery* 18-25.

always involve claims of "obstruction", "inadequate handover" or "delayed transfer", all of which are based on the mistaken notion that a PPM exists purely to accommodate hospital policies and procedures. It is a mistaken notion supported by the NMBA, which uses nurses and hospital midwives to investigate and determine the future of PPMs.

Hospital staff also resent PPMs providing information to the woman that challenges or contradicts any biased or misleading information being put forward by facility staff. This too highlights how much hospital staff depend on misdirecting and misinforming women in their care. In one particular case, the medical practitioner and midwifery manager together lodged a complaint against a PPM for "obstruction". According to the woman, she was repeatedly shouting 'no' but the doctor continued to put on his gloves and attempt a vaginal examination as if she wasn't conscious. The PPM put her hand in front of the woman and asked the doctor to stop. To be clear, these are situations where there are several people – including hospital midwives - in the room, who know that what they are doing is against the law, but the only one brave enough to say anything is the PPM.

PPMs regularly pay the price for trying to protect women from facility based assault. Even the complaint amounts to nothing, they are scrutinised by the NMBA for several months and in some cases made to cease practice until an investigation is finalised. The costs are personally borne and can be profound. PPMs do not have insurance for intrapartum care, which ordinarily provides legal representation. Most PPMs cannot afford legal representation.

9.Consequences of Obstetric Violence

> *"I've recently seen an example of what I would call obstetric violence, and it showed me that sometimes it doesn't matter how educated or empowered the woman is, sometimes obstetricians just feel as though their medical training gives them authority over a woman's body during labour and birth.*

We can make reports and we can escalate them, but this perceived authority seems to be a culture amongst a significant proportion of obstetricians."

In Tasmania, it is clear that careproviders are abusing the power differential they hold to their advantage in the birth room. The asymmetrical relationship between women and careprovider is reinforced by a team of people, devices, technological aids and resources designed to support the doctor, while the labouring woman only has a fearful and equally powerless partner at her side.[79] They do not stand a chance against and struggle to deal with bullying, coercive practitioners. In fact, careproviders have become so accustomed to this power imbalance that the presence of anyone familiar with hospital processes, such as doulas or PPMs, appears to offend them.

For too long, victims of obstetric violence and their families have suffered in silence.[80] The careproviders who seek to protect and defend women have also suffered in silence.[81] We have represented clients and complainants who, following their birth, suffered:

- permanent physical injury

I had huge issues with my c-section scar and was not told of the importance of gentle massage of the scar area to help with

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[79] Ellen D Hodnett et al, 'Home-like versus conventional institutional settings for birth' (2005) *Cochrane Database of Systematic Reviews* 1; JD Harte et al, 'Application of the Childbirth Supporter Study to Advance the Birth Unit Design Spatial Evaluation Tool' (2016) 9(3) *HERD: Health Environments Research & Design Journal* 135-61.

[80] Daniels et al, "Be Quiet and Man Up: a Qualitative Questionnaire Study Into Fathers Who Witnessed Their Partner's Birth Trauma" (2020) 20 *BMC Pregnancy Childbirth* 236; E Moran et al, "The Paternal Experience of Fear of Childbirth: An Integrative Review" (2021) 18(3) *Int J Environ Res Public Health* 1231

[81] N Uddin et al, "The Perceived Impact of Birth Trauma Witnessed by Maternity Health Professionals: A Systematic Review (2022) 114 *Midwifery* 103460; Justine Toohill et al, "Trauma and Fear in Australian Midwives 32(1) *Women & Birth* 64-71.

healing. I had issues right down to my ankle because tissues etc were fusing together.

During birth in 2012 I was injured with an episiotomy and now have an ongoing birth injury that is not healable.

- suicidal ideation, attempted or committed suicide[82];

Postnatal depression, postnatal anxiety, breastfeeding trauma & inability to establish breastfeeding. Postnatal rage & suicidal thoughts. Never thought I'd have another baby, took me 4 years to do it again & had an elective this time. I had to see multiple psychologists as well.

- self-harm, particularly with alcohol abuse;

- rejected their infants;

"The emotional toll of this birth was huge, it took me over a year to be able to properly bond with my baby. I will never get that time back."

"When I saw her I didnt feel like she was mine. She could have been anybody's baby."

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[82] Sohrab Amiri & Sepideh Behnezhad "The Global Prevalence of Postpartum Suicidal Ideation, Suicide Attempts, and Suicide Mortality: A Systematic Review and Meta-Analysis" (2021) 50 *International Journal of Mental Health* 4; Sohrab Amiri & Moien Ab Khan, "Prevalence of Non-Suicidal Self-Injury, Suicidal Ideation, Suicide Attempts, Suicide Mortality in Eating Disorders: A Systematic Review and Meta-Analysis" (2023) 31(5) *Eating Disorders* 487-525

- suffer complex PTSD, anxiety and depression[83];

"I am only 3 weeks postpartum, however the emotional and psychological impact of my birth has already affected me and my ability to mother my newborn greatly. My anxiety has skyrocketed in the wake of my birth trauma, creating the need for long appointments with my GP and psychologist, and debriefing with my doula, all of which have a significant cost attached. This comes after being tens of thousands of dollars out of pocket for IVF and private OB/hospital fees over the past 18 months. I am needing to go back on my anxiety medication after successfully being off it for two years previously. I am not able to trust my own judgement as a mother and lean heavily upon my partner for support, however he now needs to return to full time work to pay our medical bills. I am Unable to drive, and this affects my ability to care for our school aged child and further affects my mental health by being trapped in the house all week. I feel let down by the system and my provider, that their actions and policies led to my birth trauma and I/my family are the ones who have to deal with the consequences going forward."

"I have OCD anxiety and depression and would always have bad thought about my baby dying in labour..."

- suffered relationship breakdowns;

[83] Stephanie Zaers, Waschke, M & Ehlert U, "Depressive Symptoms and Symptoms of Post-Traumatic Stress Disorder in Women After Childbirth (2008) 29(1) *Journal of Psychosomatic Obstetrics and Gynaecology* 61-71; Rebecca Grekin et al "The Role of Prenatal Posttraumatic Stress Symptoms Among Trauma Exposed Women in Predicting Postpartum Depression" 38(3):*Stress Health* 610-614

"I struggled immensely in the months afterward and did not bond with my baby immediately. During my second pregnancy, I had to receive intensive therapy leading up to the birth as I was so traumatised by my first birth and fearful the same thing would happen again. My partner and I have since separated due to the strain placed on our relationship due to the impacts of my first birth."

"Seperated from child's father , more mistrust in system. Breastfeeding low supply , undue stress"

- lost their jobs;
- lost their private midwifery practice;
- lost their homes to cover their legal fees;
- relinquished their careers;
- struggled to re-enter the workforce;

"I have suffered from post natal depression and anxiety from the trauma I experienced in hospital. Part of this being the trauma of not being able to hold my child for 24 hours and being refused to do so! I [had] a mental breakdown. I have been unable to return to work."

- became permanent carers for infants with injuries;

I still have depression and anxiety, both daughters have psychological, and physical issues which I attribute a percentage to what happened to them in the hospital . I didn't bond with my first daughter and this is still an issue today. I also was very withdrawn from my husband too.

- incur significant out-of-pocket costs seeking psychological or psychiatric care or specialist care for nerve damage, pelvic floor injuries, surgical complications and third to fourth degree perineal tears;

Short term I had significant distress and even struggled taking my daughter to clinic appointments for infant care. I entered psychological treatment at 7 months post-partum and have been lucky to not need to pay a lot for this.

We have encountered far more financial costs associated with my birth injuries than we ever thought we would, and many of these are ongoing - regular physio, pelvic floor physio, women's health GP, private gynocologist, medications...it doesn't end.

Financial impacts - no supports for premature births or extended hospital stays. Physical - unable to be seen by physios, allied health to support postnatal care as system only taking the most urgent cases. Otherwise would have to access privately and fees are expensive. Emotionally not supportive and cared for. Almost forgotten about. Just another number in the system. Not treated like a genuine person. Birth trauma Emotionally and physically and no supports provide as support worker and mental health are too backed up, unable to support.

- endure faecal incontinence;
- terminate pregnancies;

All I have ever wanted since being a young child, being an only child myself is to have 3 children. I now don't think I will ever be able to have another baby with what I had to go through to feel seen...

- reject medical careproviders, especially vaccinations;

I feel robbed by so many so called "health professionals" who completely ruined my experience, which, after two amazing home births, I can see can be an absolutely beautiful rite of passage without all this unnecessary carryon, and that you can

feel amazing and happy postpartum, instead of feeling like you were run over by an LGH truck.

I will never birth in the hospital system again (unless due to an emergency). I don't know if I'll ever have another baby, but if I do, I will only have a home birth.

For me.... My next birth will be a free birth. I do not trust medical professionals at all. I trust myself.

- become isolated;

PTSD, PPA, strained relationships, loss of family due to strained relationships, financial losses, permanent scarring and damage to myself.

- suffer domestic violence.

What is clear from the reports we received is it that it is time for governments to intervene and level the playing field for women, as is required in accordance with their rights as consumers, to respect their right to equality before the law, freedom from discrimination and to be protected from gender-based violence in accordance with goverment obligations as signatories to CEDAW.

Women have been complaining about abuse and mistreatment in maternity health facilities for decades. These complaints – clear violations of our human rights – have rarely been acknowledged, let alone addressed, and have made no difference to institutional practice. As shown above, careproviders have only responded to liability threats by engaging in *more* coercive and dehumanising practices to protect themselves. We can no longer expect to rely on careproviders to make these much needed changes without the imposition of legal accountability and consequences that incentivises them to adjust practice to recognise women's human rights. There is an added bonus: *informed consent vitiates medical liability.*

We ask the Committee to consider the submissions of women – many of which are disturbing to say the least – and to adopt recommendations we offer to address these problems below.

Recommendations

The following recommendations are based on Australia's obligations (a)-(e) specified by CEDAW and supporting caselaw. All governments of countries signatory to CEDAW must observe the following obligations:

> ***(a) The obligation to provide quality health-care services i.e. services that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.***[84]

In answer to this obligation, we recommend:

- Dept of Health to review, and instruct maternity hospitals to review and amend all maternity health care policies and guidelines which do not respect the human rights of women and pregnant people;
- Dept of Health to review and oversee applications for accreditation and visiting rights by PPMs to publicly funded facilities, independently of the hospitals;
- All careproviders (public and private) to, at the time of booking, give the woman a form listing routine procedures used and relevant policies applied by the facility and/or by the careprovider

[84] UN Committee on the Elimination of Discrimination Against Women (**CEDAW**), *CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, 1999, A/54/38/Rev.1, chap. I, available at: https://www.refworld.org/docid/453882a73.html [accessed 16 August 2023].

with check boxes so women can use that form as a birth plan and to initiate discussions during ante-natal visits;

- Dept of Health to issue mandatory guidelines to facilities, LHDs, ambulance and the police force on facilitating respectful home to hospital transfer for women regardless of the circumstances of their birth and a requirement that staff remain respectful of the relationship between the woman and her support persons or PPMs at all times;

- Develop a phone app which enables women to choose the model of care that suits their choices and preferences, which includes information provided by LHDs on each facility's admission and intervention rates, and any unique services they offer such as breech birth, birth centres or midwifery group practice or homebirth;

- Aim to implement midwifery continuity of care as the minimum standard of care throughout Tasmania by 2028;

- Reduce or remove restrictions on consumer intake into birth centers and midwifery group practice;

- Double the number of birth centres and Midwifery Group Practices until midwifery continuity of care is fully implemented.

(b) The obligation to establish, publicise and implement a Patients' Bill of Rights, with access to effective remedies in cases in which women's reproductive health rights have been violated, including in cases of obstetric violence.[85]

In answer to this obligation, we recommend that the Tasmanian Government:

- Develop legislation containing a Health Care Consumer Bill of Rights (in consultation with women and human rights lawyers) which:
    - includes provision for protection from obstetric violence and recognises the right to informed consent and to choose or refuse treatment;
    - authorises consumer video and/or audio recordings in birthing suites;
    - provides consumers with an avenue to complain against careproviders and/or facilities for breaches of the Act to Ahpra for investigation; and
    - gives consumers standing to commence proceedings against facilities and individual careproviders for rights violations, including obstetric violence.

[85] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [16(b)(v)]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [8(b)(iv)].

(c) The obligation to adopt legal and policy measures to protect pregnant women from and penalize obstetric violence, strengthen capacity-building programmes for medical practitioners and ensure regular monitoring of the treatment of women in maternity health-care centres and hospitals.[86]

In answer to this recommendation, it is essential that the Tasmanian Government:

- Establish an independent body which works with Ahpra to:
    - monitor and report on rights violations and violence against consumers;
    - commence investigations against individuals and facilities following a complaint or of its own initiative;
    - issue strict liability penalties against facilities or careproviders found to have engaged in (defined) 'minor' violations;
    - commence proceedings, on behalf of consumers, against facilities for (defined) major or repeat violations;
    - refer serious or repeat incidences of obstetric violence to the police;

[86] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [15.5].

(d) The obligation to take all appropriate measures to modify or abolish not only existing laws and regulations but also customs and practices that constitute discrimination and the endorsement of harmful gender stereotypes against women.[87]

In response to this obligation, we ask the Tasmanian Government to:

- Repeal section 13(1)A of the *Children, Young Persons and Their Families Act 1997* (TAS) or amend the legislation to make it clear that section 13 (1)A does **not** authorise the CSD to coerce pregnant women into accepting medical treatment;
- Ensure that all consumers are provided with the Health Care Consumer Bill of Rights including avenues for complaint, prior to their utilisation of said health services;
- Mandate annual professional human rights training for obstetricians, midwives, ambulance personnel and other health professionals on women's reproductive health rights, obstetric violence, harmful gender stereotypes and adherence to the Health Care Consumer Bill of Rights.[88]

[87] UN General Assembly, Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979 (Res 34/180 of 18 December 1979, Entry into force 3 September 1981), Art 2(f), 5.

[88] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [16(b)(iii)]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [8(b)(iii)].

e) Provide specialized training to judicial, administrative (i.e. CSD) and law enforcement personnel to recognise structural discrimination based on harmful gender stereotypes regarding pregnancy and childbirth.[89]

[89] *N.A.E v Spain* [2022] CEDAW C/82/D/149/2019, [16(b)(iv)]; *S.F.M v Spain* [2020] CEDAW C/75/D/138/2018, [8(b)(iv)].