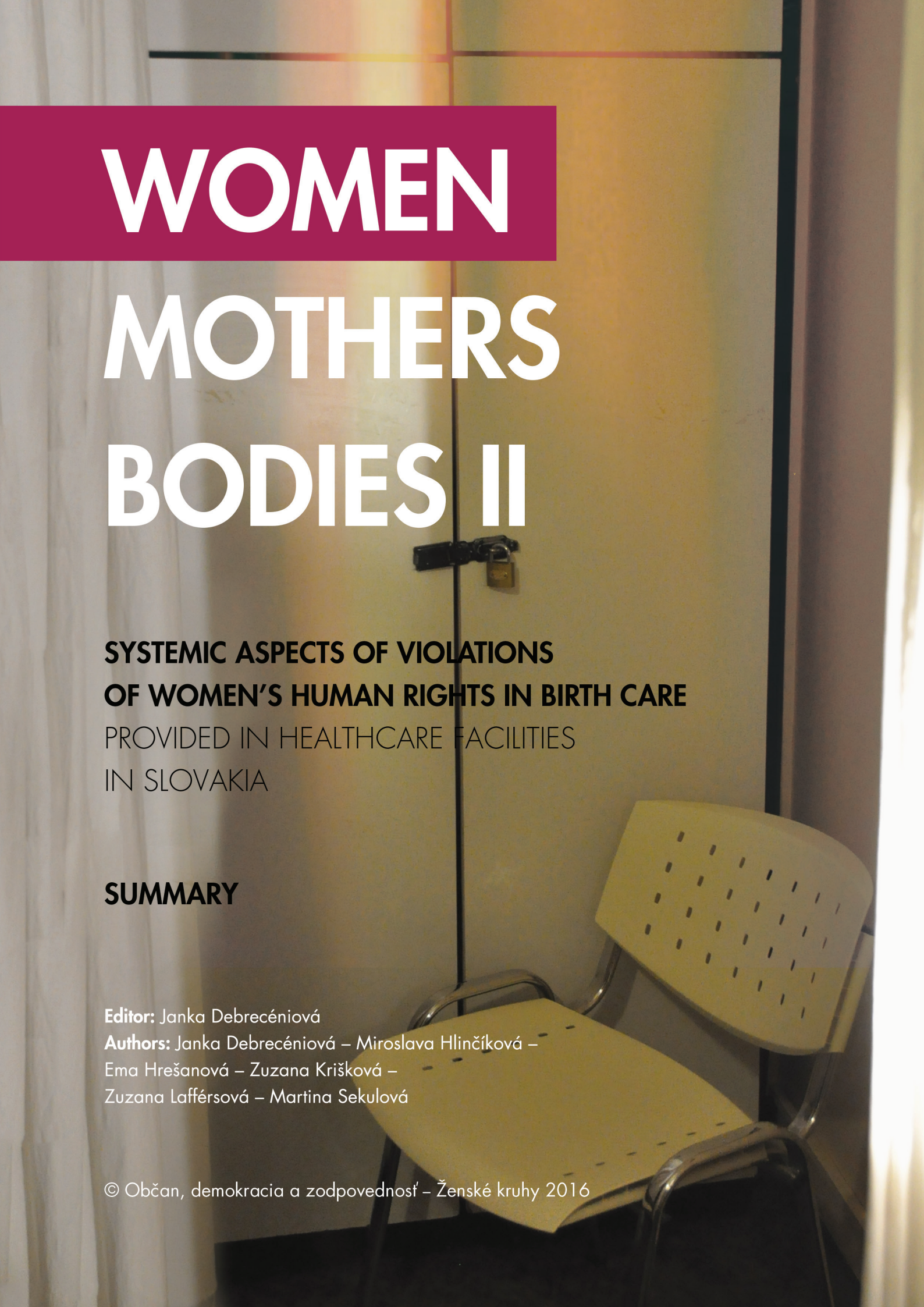

WOMEN MOTHERS BODIES II

SYSTEMIC ASPECTS OF VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN BIRTH CARE PROVIDED IN HEALTHCARE FACILITIES IN SLOVAKIA

SUMMARY

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The aim of the Project ***Supporting implementation of Slovakia's obligations in the area of women's human rights to promote system changes in the elimination and prevention of discrimination against women, including gender based violence by public institutions***
is **the support of democratic values including human rights.**

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Občan, demokracia a zodpovednosť, Ženské kruhy

2016

Women – Mothers – Bodies II

Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia

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Summary

Objectives and Key Features of the Publication

Hospitals are the only places where women can receive state-guaranteed birth care in Slovakia. There are no alternative options, such as, for instance, birth centres led by midwives or an official home birth system organised by the state. However, birthing facilities represent relatively closed institutions with weak public and government control mechanisms, where decisions are made, and rules set by their management (mostly consisting of males) and healthcare personnel. Therefore, the aim of the research whose results are presented in this publication was to look at and examine the institutional aspects of birth care provided in Slovak hospitals.

The publication *Women – Mothers – Bodies II: Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia*[1] that we are presenting to you now is a follow-up elaborating further on our previous findings on the violations of women's human rights in birth care provided in healthcare facilities across Slovakia, as well as on the infringements of internationally recognised medical guidelines related to birth care (we included a majority of these findings in our 2015 publication entitled "*Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia"*; hereinafter only referred to as "*Women – Mothers – Bodies I*"[2]). The present publication builds to a large degree on in-depth interviews with women and on their birthing experience in selected birthing facilities in Slovakia and on the monitoring of certain aspects in the provision of birth-related care, covering all birthing facilities in Slovakia (the findings from the interviews and the monitoring were previously presented in *Women – Mothers – Bodies I).* The publication also presents the views of obstetricians and midwives.

The present publication is divided into three interrelated chapters. The first of these presents childbirth from the perspective of cultural anthropology. It emphasises that childbirth is always part of a wider social and cultural context and contends with a narrative prevailing in Slovakia, according to which childbirth is perceived as a medical issue, the relevant knowledge of which is solely held by healthcare personnel. The second chapter introduces the main human rights standards that must be complied with during the provision of birth care and are embedded both in national and international law. This second chapter also provides a brief summary of specific cases of the violations of women's human rights during childbirth in Slovak birthing facilities that have previously been described in *Women –*

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[1] The publication (in Slovak) is also available at: http://odz.sk/zeny-matky-tela-2-systemove-aspekty/ (last visited on 3 December 2016). The Slovak title of the publication is: *Ženy – Matky – Telá II: Systémové aspekty porušovania ľudských práv žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku.*

[2] DEBRECÉNIOVÁ, J. (ed.); BABIAKOVÁ, K. – DEBRECÉNIOVÁ, J. – HLINČÍKOVÁ, M. – KRIŠKOVÁ, Z. – SEKULOVÁ, M. – ŠUMŠALOVÁ, S.: *Ženy – Matky – Telá: Ľudské práva žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku*. [Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia]. Bratislava : Občan, demokracia a zodpovednosť, 2015. Also available at: http://odz.sk/wp-content/uploads/Z-M-T_publ_el1_pod_sebou.pdf (last visited on 16 October 2016). An English summary is available at: http://odz.sk/en/wp-content/uploads/Women-Mothers-Bodies_summ_EN.pdf (last visited on 16 October 2016).

Mothers – Bodies I. The third, most extensive chapter draws on new qualitative research based on interviews with healthcare personnel – obstetricians and midwives – following up on the previous findings from the interviews with birthing women.

The conclusion that the violations of women's human rights during childbirth in Slovak hospitals are not only the result of individual faults but are largely of a systemic nature was presented previously in *Women – Mothers – Bodies I*. The systemic and systematic violations of women's human rights in the provision of birth care in Slovakia is further significantly enhanced by the fact that both symbolic and real power lies in the hands of healthcare personnel, not in the hands of women. The existence and further reinforcement of this asymmetric relationship and set of human rights violations is driven by a multitude of settings in the provision of birth care. When writing this publication and conducting the research on which it builds, this problematic relationship was one of the reasons we focused on a wide range of factors leading to or accompanying such violations, in addition to providing a detailed description of individual cases of women's rights violations. We have described several causes, connections, and links, and various other systemic aspects related to the violations of women's human rights in Slovak birthing facilities. The phenomena described and analysed here include, for example, the education and training of healthcare personnel; the absence of national-level medical guidelines on the provision of birth care; power and hierarchical relations among the personnel; the misunderstanding of the informed consent concept by the healthcare personnel and/or the misunderstanding of the concept of human rights in general; or the organisation of work in birthing facilities. This text also presents some examples of good practices which may serve as an inspiration for redesigning the birth care system in Slovakia.

Chapters' Overview and Summary

1. Birth from the Perspective of Cultural Anthropology

This chapter introduces the fundamental bases of the anthropology of childbirth, a sub-discipline of cultural anthropology which studies cultural and social aspects of birth in various social and historical contexts. Research in this area has shown that the course and circumstances of labour and delivery differ considerably in various societies, despite the fact that childbirth is a universal part of female physiology.

Birth always reflects fundamental cultural values and social processes prevailing in a given community. Studies into birth care systems that exist in the US and the Western World reveal, for example, society's fascination with sophisticated technologies, which people perceive as superior in value, while anything that is associated with the natural world and unrelated to technology is often considered inferior. However, technology and machines also function as a basic cultural metaphor. In Western Civilisation, this metaphor is used, for example, to better understand the function of the human body. From this perspective, the human body is something that resembles a sophisticated machine, a machine that is predictable and can be repaired if it breaks down. This Cartesian view of the human body is based on the model of a young male body with clear lines and predictable physical processes, one that better fits the prevalent "machine" metaphor. By contrast, a female body with its numerous curves, one that often changes, for example, according to the menstrual cycle, necessarily appears as defective in comparison to this standard. Therefore, when applied to obstetrics, the

Cartesian conception of the human body is necessarily associated with an interventionalist approach to childbirth.

Social scientists analyse in detail the symbolic meaning inherent in medical language, revealing significant power inequalities between the medical personnel and birthing women, as well as other persons present at childbirth. Comparative cross-cultural studies warn that technology-based birth care systems show a clear tendency to overlook the fact that a labouring woman also possesses certain knowledge of and insights into birth-related issues. The knowledge owned by obstetricians is perceived as so-called "authoritative knowledge" in this social and cultural context, which means that it is taken as the only correct and viable practice, while other systems of knowledge owned by women themselves or by those of other professions, such as midwives or doulas, are often considered dubious and incorrect. In short, the factual correctness of a given sum of knowledge is not necessarily the decisive factor, but instead centres on the credibility a given community or social group ascribes to a particular knowledge system.

The question that the anthropology of childbirth asks in this regard is what exactly led to a certain type of knowledge being established as authoritative throughout the course of history. This is where anthropological studies overlap with historical studies not only into obstetrics, but into midwifery as well. Such research shows that the path towards the victory of modern obstetrics over the realm of birthing was not the same everywhere, nor was it straightforward or simple. Researchers and scientists use the medicalisation concept in this context. It refers to a process when an originally social problem is re-defined as a medical problem which is then described by means of medical terminology and treated as a medical condition managed and controlled by health professionals. Childbirth was long taken as a natural part of women's physiology and life cycle; however, after it was reconceptualised into a medical problem that could be managed medically, it was moved to a hospital setting where doctors could perform their work in an environment equipped with advanced technology. Beyond any doubt, medicalisation focused on the potential of medical technologies not only affects the medical approach to the process of birth and to birthing women, but it also influences how women in modern society look at their bodies. The negative implications of this may include women's alienation from their bodily and childbirth experience. Medicalisation has, therefore, become an important object of criticism by many women and women's movements.

The criticism of a birth care system overly relying on technology leads to its change. More and more new actors appeared in maternity wards at the beginning of the 21st century, and besides the renaissance of midwifery, doulas are among the most significant examples of this development. The institutional context of the birth care provision is changing as well. Cultural factors, having an impact on procedures in birthing facilities, play an important role in the provision of birth care. In this context, the anthropology of childbirth studies the culture-related specifics of individual facilities, using, for instance, the concept of organisational culture that can be analysed on several levels. An example we give in this chapter includes a study carried out in two Czech maternity hospitals, analysing them on three different levels. At the micro level, the analysis discusses interactions between individual members of the organisation, particularly between healthcare personnel (obstetricians and midwives) and clientele (women giving birth and their partners). On the next analytical level – the mezzo level – the analysis examines, for example, the process of the professionalisation of midwifery. On the last, macro level, it focuses on wider social processes that affect the conditions and environment inside these facilities, such as consumerism or increasing social and economic inequalities, as well as economic and political factors that influence the whole healthcare system.

2. Human Rights as the Normative Basis, Desired State, and Interpretation Framework for the Provision of Birth Care

The second chapter describes the basic international and national standards on women's human rights applicable to the provision and receipt of birth-related care. At the same time, drawing on the *Women – Mothers – Bodies I* publication, it provides an overview of how these rights are being violated in birthing facilities in Slovakia.

Pregnancy, childbirth, and birth care primarily and directly affect women. At the same time, they have implications on women's sexuality and reproduction as well. Therefore, the rights related to pregnancy, childbirth, and birth care are called the sexual and reproductive rights of women. Below are the rights particularly affected by childbirth:

- the right to human dignity;
- the right to the protection of health, to sexual and reproductive health, and to healthcare;
- the right to information and informed consent;
- the right to the protection of private and family life;
- the right to equality and non-discrimination;
- the right not to be subject to violence, torture, and other cruel, inhuman, and degrading treatment;
- the right to enjoy the benefits of scientific progress and its application.

In the international context applicable to the Slovak Republic, these rights are contained in UN human rights conventions and Council of Europe conventions, and further elaborated upon by individual UN committees and the European Court of Human Rights. Pursuant to the Constitution of the Slovak Republic, these conventions in principle take precedence over Slovak legislation.

At the national level, these rights are explicitly or factually contained in a number of legislative regulations in various fields. The important legislative sources are mainly the Constitution of the Slovak Republic and the Healthcare Act, but relevant provisions can also be found in other pieces of legislation, such as the Antidiscrimination Act, the Civil Code, and the Criminal Code.

The duty to respect, protect, and fulfil women's human rights during childbirth is primarily vested with the state and state authorities. However, healthcare facilities and individuals providing health care are also always liable.

As shown in *Women – Mothers – Bodies I* and also confirmed by the present publication, women's human rights are being violated to quite a large degree in healthcare facilities across Slovakia. Violations occur with respect to all of the aforementioned rights.

Women – Mothers – Bodies I describes examples of violations of birthing women's right by healthcare personnel, occurring through all stages of the childbirth process. These include violations of the right to dignified and respectful treatment without coercion, manipulation, and intimidation, instances of birthing women being treated as non-autonomous objects on which healthcare is "performed" based on the decisions made by the healthcare personnel, as well as violations of women's right to information and to informed decision-making, followed by the unauthorised interference of their physical and

mental integrity, for example, in the form of medical interventions performed on them. Moreover, the interventions and practices applied were often in conflict with internationally recognised medical guidelines. The treatment of birthing women often included elements of physical or psychological violence.

In the research, the right to information was violated as early as at the stage of selecting a healthcare facility in which to give birth. Comprehensive and sufficient information about individual facilities and the practices and procedures they employ were extremely difficult to obtain – bordering on impossible – from most Slovak birthing facilities. The violation of women's right to information by individual birth care providers led, logically and inevitably, to the violation of their right to the freedom of choice of their care provider.

However, the right to information was violated throughout the entire birthing process, from the arrival at the hospital through to the stay in the postnatal ward. One of the examples of the right to information being violated that all the women participating in the research interviews mentioned is that they all had signed a standardised form of the so-called "informed consent" without being first given sufficient and comprehensible accompanying information to know exactly what they were made to sign. There were, however, other examples of how their right to information and/or their right to informed consent/informed decision-making were violated as well, for example with respect to the medical interventions they received, including the routine prophylactical use of cannula, the administration of various medications, the rupture of membranes, the performing of an episiotomy, and the use of Kristeller's expression/fundal pressure. Many of the women interviewed recounted that these interventions were often performed without their prior consent, and sometimes even without their knowledge. There were also instances where interventions were performed despite women's express refusal. They were informed of some interventions only afterward, or not at all.

Various and frequent violations occurring throughout the whole birthing process and stay at the birthing facility were also reported with respect to the right to the protection of private and family life. Examples include the way hospital rooms and their furniture were arranged and/or how the workflow in a particular facility was organised (for example, birthing rooms being shared by several women; birth chairs being positioned towards a door or an aisle; and fathers of newborn babies not being allowed to visit their partner and children), as well as the healthcare personnel's behaviour (entering rooms without knocking; leaving the door to a birthing room open; directly after birth, leaving a woman in a corridor open to the public, only covered by a gown and equipped with a bowl to urinate in; allowing the presence of unwanted persons – both in terms of their type and number – in the room where a woman was giving birth; and examining women during doctor's visits not only in the presence of other doctors, but also in the presence of other women in the room). The right to privacy was also violated by preventing women from freely choosing a birthing position during both the first and second stages of labour, as well as by keeping the mothers from creating an emotional bond with their babies, including due to the absence of support for undisturbed and permanent skin-to-skin contact between mothers and their newborn babies immediately after birth.

Women – Mothers – Bodies I also revealed numerous aspects of violent and cruel treatment of birthing women. One such example is that women could not freely choose a birthing position that would suit them best and help relieve their pain. During the first and second stages of labour, women were forced to remain in an uncomfortable, inconvenient, and painful supine position; some of them even said during interviews that they had their legs fixed up in stirrups during the second stage. Another form of infringing upon the right to the provision of birth care free from violence was the use of the so-called Kristeller's expression/fundal pressure to speed up delivery. This procedure was extremely painful and,

according to the accounts the women gave during our interviews, it was routinely performed without prior consultation, and often even without the woman's consent. A routinely performed episiotomy, an intervention often mentioned in the interviews, can also be considered a form of violent, cruel, and inhuman treatment. We also obtained information about the painful suturing of perineal tears, a practice also infringing upon the right to birth care free from violence, torture, and cruel, inhuman and degrading treatment. With respect to the aforementioned right, we were even told about situations when women were routinely prevented from drinking and eating, even after childbirth. The previously mentioned routine separation of women from their newborn babies, as well as healthcare personnel manipulating and intimidating women, ridiculing them, and doubting or ignoring their feelings and the pain they suffer can also be perceived as forms of violent and degrading treatment.

Some of these procedures and practices – for instance, preventing women from freely choosing a birthing position or from drinking and eating during labour, routinely performed episiotomies and Kristeller's expressions/fundal pressure, painful perineal suturing or the routine separation of women from their newborn babies – are also in conflict with internationally recognised medical guidelines. The non-compliance with these guidelines constitutes a breach of the right to enjoy the benefits of scientific progress and its application.

In addition to the aforementioned and other violations of rights during childbirth discriminating against women in general, as pregnancy and birth-related care affect women only, some ways the birthing women were treated also presents discrimination against specific groups of women. The fees charged for having an accompanying person present during childbirth, for epidural analgesia, and for "extra standard" birthing/hospital rooms – which ensure privacy to women unlike the "standard" rooms – can be considered discriminatory especially against women with low or no income.

Many of said violations are also in conflict with the right to health and its components – availability, accessibility, including affordability and information accessibility that are free from discrimination, acceptability, and quality.

3. Manifestations, Causes, Accompanying Characteristics and Other Systemic Aspects of Women's Human Rights Violations during Births in Healthcare Facilities in Slovakia – Findings from In-Depth Interviews with Healthcare Personnel and Women

Background, Perspectives, Objectives and Methodology of Research

The parameters of the research were set with women's human rights in mind. The complexity of such a diverse field of research as health care and, specifically, birth care, was a great professional and methodological challenge. Due to the strong normalisation of human rights violations during childbirth and the power and authority medicine as science and as profession generally holds in our society (but in other societies as well), we felt the need to analyse and interpret the collected data very carefully. Therefore, we chose the specific approach of gradually "uncovering" the many layers and dimensions of the collected data. This approach was based on theoretical concepts of social sciences, namely

social anthropology (and the anthropology of birth) and law. We also applied feminist critique.

The primary source of data was interviews with healthcare personnel – obstetricians and midwives. We followed up on the findings from our previous survey, i.e., on the findings from the interviews conducted with women who had experienced childbirth, and on the findings obtained from other human rights monitoring activities (which had already been published in *Women – Mothers – Bodies I*). When analysing and interpreting the data, we combined and compared the views and opinions presented by the women as well as by healthcare personnel, seeking to show where they differ and where they converge.

The first research phase, the qualitative survey on women's birthing experience in some of the birthing facilities in Bratislava (the capital of Slovakia) or in the Trnava district, was carried out in the form of in-depth semi-structured interviews conducted in July and August 2014. The research sample consisted of 15 women. The first phase of data collection also involved a monitoring exercise, running from July through October 2014, that covered all birthing facilities across Slovakia. The monitoring attempted to identify the real options the women planning a childbirth (and the general public as well) have at their disposal in order to obtain information about individual birthing facilities, how these facilities ensure the provision of birth care, and how they fulfil women's human rights. The second phase involved qualitative research conducted by means of in-depth semi-structured interviews with three male and three female obstetricians and four midwives (ten interviews in total) regarding their work in birthing facilities in Slovakia. The interviews were conducted between December 2014 and February 2015. The respondents were selected so that the chosen sample reflected their different positions within the hospital hierarchy and the length of their professional experience, and so that the sample included respondents working in hospitals in Eastern, Central, and Western Slovakia. When putting together the research sample, we also considered the number of births taking place in respective birthing facilities per year, dividing them into "small", "medium-sized", and "large". In order to ensure the highest level of anonymity, the identity of all respondents was strictly anonymised during the analytical stage as well. We assumed that the knowledge of a respondent's identity could affect the interpretation of the findings, and disclosing these identities could potentially affect the professional or private life of the respondents. Both for the interviews with the birthing women and the healthcare personnel, the specific data by which respondents could be identified (name and surname, place of respondent's work, size of the birthing facility and number of births per year, town/municipality, etc.) were only known to researchers conducting the interviews and were not disclosed to the wider research team. The research team had only anonymised transcribed interviews at their disposal.

The text also incorporates available evidence-based data on individual aspects of birth care, derived mostly from the guidelines, interpretations, and recommendations issued by internationally recognised professional organisations (WHO, FIGO, NICE and ACOG).

Women's Human Rights in Childbirth and How They Are Reflected in the Exercise of Informed Consent, Communication with Women and Respect for Their Decisions

This chapter provides insights into the concepts of both the provision of information and informed consent. It discusses how these rights are fulfilled (or not) in the context of the healthcare provided in birthing facilities across Slovakia and examines the mechanisms the healthcare personnel use to restrict, or even deny, the women their right to information and informed decision-making, as well as the mechanisms and strategies women attempt to employ (often with no success) in order to have their

rights and demands respected and fulfilled. Further, it discusses other important circumstances and conditions that complicate, or even prevent, effective communication and cooperation with birthing women. These circumstances also have crucial impact on the overall atmosphere in the birthing room and on women's feelings of safety, respect, and dignity, as well as on the overall psychological and physical experience of the actual labour and delivery and the lifelong memories of this experience.

The interviews revealed that healthcare personnel are not familiar with what women's human rights in childbirth include and are unable to understand this concept; they do not consider the fulfilment of women's human rights in childbirth an integral part of their work, but deem it something "extra". Women's human rights in childbirth as a fundamental concept and framework remain generally misunderstood and unidentified in the Slovak institutional context of providers of birth care.

The interviews with both the healthcare personnel and the women indicated that as long as women give birth in a hospital setting, they are implicitly expected to conform to the institutionalised set of rules. The imbalance of power to women's disadvantage is further reinforced by the fact that doctors and midwives have professional knowledge and experience, and the hospital is an environment they are thoroughly familiar with, functioning according to the rules set and controlled directly by them. This means that while for the healthcare personnel, a childbirth is a routine procedure with no implications on their physical and often also on their mental well-being, for women it is a very important and extremely intimate moment in their lives that unfortunately often takes place in an unfamiliar, sterile, and ofttimes uncomfortable setting in the presence of unfamiliar and mostly unknown persons on whom the birthing women depend. Moreover, many women put themselves in the hands of healthcare personnel with full confidence.

Healthcare personnel perceive informed consent as a formal expression of consent to a proposed procedure, often reduced to simply obtaining a woman's signature on a printed form. The way the informed consent form is designed and used in Slovak birthing facilities clearly shows that its primary purpose is to obtain women's "consent" to routine procedures and practices applied in birthing facilities. Women are automatically expected to sign the form. None of the interviews included any mention that a woman had not signed the form, or that she had been advised by the healthcare personnel on her right not to sign the informed consent form.

Most often, women are given very little information, and if they receive information, they are only informed about what the healthcare personnel have decided to do with them. Thus, women are not expected to make their own decisions based on the information they receive. In some cases, information about the medical procedures to be performed is not provided at all. In addition, healthcare personnel view the provision of information – albeit still limited to information about decisions they have already made with regard to the birthing women – as a sort of "extra service" or a possible "added value" in the case of uncomplicated births. The lack of time in emergency and/or unforeseen situations has thus become an argument and excuse for not providing adequate information to women. The interviewed healthcare personnel did not mention any means that could help ensure women's right to information and informed consent in emergency situations as well.

The provision of incomplete and imbalanced information by the healthcare personnel also constituted a serious breach of the right to information and informed consent. Such information highlighted the positive aspects of procedures preferred by the healthcare personnel while concealing their risks and/or omitting information about other potential procedures that may present greater benefit for the women in labour. Some of the proposed procedures were not in line with current scientific evidence. In some cases, hospital personnel used manipulation and/or intimidation to obtain "consent" from the

women, or even performed particular interventions against the women's expressed refusal.

In a few cases, healthcare personnel admitted that women should be encouraged and have room to ask questions. These personnel were aware that not all women must necessarily understand the specific medical terminology. However, there were also examples when the personnel would see additional questions asked by women as inconvenient and delaying of their work.

Healthcare personnel only rarely acknowledged that they should actively attempt to learn women's preferences and needs. They did not consider obtaining information from women an integral part of their work and an obligation to provide healthcare solely on the basis of informed consent.

Slovak birthing facilities provide very little room for women to make their own decisions about childbirth. Recording written birth plans or wishes and communicating them directly to the hospital personnel has become an instrument and strategy women employ to ensure that their rights are at least partially respected in birthing facilities that do not inquire about women's preferences and expectations, and that fail to respect women's rights. From this point of view, the birth plans now represent a mechanism the women use in order to bargain for something to which they should automatically be entitled, something that healthcare facilities and healthcare personnel should provide on their own initiative.

Demands and expectations the women participating in our research wrote down in their birth plans/wishes were related to the fulfilment of their human rights with respect to the protection and respect for their dignity, privacy, and intimacy. As regards medical procedures and interventions requested by the women in our research, the majority of them asked for procedures that were in line with the latest scientific evidence, for instance, the freedom to choose a birthing position, skin-to-skin contact between mother and baby immediately after birth, or attempts to avoid harmful and/or routine practices such as the Kristeller's expression/fundal pressure, shaving, enema, or episiotomy.

Where women communicated their birth-related wishes (in writing or orally), healthcare personnel viewed their wishes in two ways. Some of their wishes were considered a sort of "extra" service that the personnel were willing to discuss because their benefits were already relatively well known and, theoretically at least, accepted. These include, for example, wishes concerning the presence of an accompanying person at birth, enema or pubic hair shaving, or skin-to-skin contact between the mother and her baby immediately after birth. However, the wishes concerning more "medical" interventions (such as a request not to speed up delivery, to avoid the routine use of some procedures such as the administering of synthetic oxytocin, episiotomy, the Kristeller's expression/fundal pressure, etc.) were seen as problematic and largely ignored by the healthcare personnel who often delegitimised and ridiculed such wishes.

Healthcare personnel often failed to conceive the birth plans/wishes provided by the women as an expression of their will by which the personnel must be bound in the context of their obligation to act solely on the basis of women's informed consent and their right to decide on the circumstances of their own childbirth, as well as other rights. Instead, personnel viewed such birth plans as "wish-lists" the fulfilment of which is subject to the discretion of the healthcare personnel and/or birthing facility management as a consequence of their "goodwill" (the interviewed healthcare personnel often used the expression "obliging"). The research revealed signs of a sort of ritual approvals of birth wishes/plans when, for example, the head of a maternity department used a red pen, official stamp, and signature to acknowledge or dismiss the legitimacy of a woman's requests. In some cases, healthcare facilities and/or healthcare personnel attempted to respond to women's written birth plans by reshaping them into informal verbal agreements (between personnel and the women) that were more difficult to utilize as evidence.

Even though the personnel generally paid attention to the birth plans, the requests and rights contained in them were often curtailed with reference to what is "practically feasible", what represents a "reasonable degree", or the personnel sought to "cut a deal" with the women, persuading them to "let it go". There were, however, some cases when the birth plans were completely ignored, or the women who had submitted their birth plans were advised to look for another healthcare facility – which in fact constitutes a denial to provide healthcare. The interviews also described situations when the healthcare personnel perceived the birth plans and wishes as a threat to their own expertise, as well as arguments akin to the idea that if a woman "wants" something from the healthcare facility, she must "conform" to its rules. In some cases, healthcare personnel even rejected the birth plans and wishes, considering them "whims", and ironizing and ridiculing them. Some of the interviewed healthcare personnel deemed women's views and ideas about childbirth naïve, uninformed, and not being their own autonomous wishes. Such an approach considerably contributes to the denial of rights entitled to birthing women.

The interviewed women repeatedly said they had decided not to write down their birth wishes because they feared the healthcare personnel would not respect them, or that a birth plan might negatively stigmatise them, and the healthcare personnel would then treat them unsympathetically during childbirth.

Expectations that women should conform to the requirements of healthcare personnel and their needs, and not vice-versa, also prevailed when discussing the cooperation between healthcare personnel and women. Communication and "cooperation" with women proved generally unequal, authoritative, and centralised around the birthing facility, its personnel, and the desired performance or outcome of birth, rather than focused on the women themselves and their positive birthing experience. Women are expected to "cooperate" with the personnel, not vice-versa. They should "listen" to and comply with their instructions and be "prepared" for birth. The specific notion of the "non-cooperating parturient" also appears in this context (this term is even used in a Slovak university medical textbook). The personnel also used the need for "cooperation" by women as an excuse for serious infringements of the women's human rights, such as the use of violence mentioned by the interviewed healthcare personnel in the form of a slap to the face or "nailing" a woman to the birthing table. The respondents also admitted that women were forced to undergo some interventions by the staff commanding them, arousing feelings of guilt in them, and intimidating and manipulating them in order to make them "cooperate", that is, obey the personnel's instructions.

These narratives thus reflect the central role played by the institution and its personnel in birth, that is, a symbolic and physical conceptualisation of birth in a way that serves the comfort, needs and preferences of the healthcare personnel rather than the comfort, needs, and rights of women. The focus on the needs of personnel is identifiable, for example, in the aforementioned conceptualisation of "cooperation" in that the personnel expect the woman to cooperate with the personnel, not that the personnel should cooperate with the woman. Further, the central role the personnel play in birth can be seen in the personnel deciding almost exclusively on what will happen during individual births instead of complying with the legal requirement to act solely on the basis of the women's informed consent and/or their informed decisions. This concentration of authority over birth by the healthcare personnel is also clearly visible in the context of the particular procedures and interventions they apply – for example, seeking not to use delivery tables that are less convenient to the healthcare personnel than classic delivery tables; preferring the supine position during childbirth; or justifying an episiotomy by stating that an incision in the perineum can be treated better and easier than natural tears – whereas these practices are in conflict with the most recent scientific evidence.

The healthcare personnel do not consider women to be competent to make judgments and decisions over individual aspects of their own childbirths: they are seen as under-informed or "too prepared" or they are "too wise". Those who express their wishes are delegitimised in many ways (e.g., they are labelled as having no idea what they are talking about; that they know nothing about birth; or they are called "nature ladies"). Equally, the personnel also belittle the feelings of pain and how women experience birth. The women's authentic emotionality during childbirth was not only perceived and assessed as something negative, but it was also subjected to gender stereotyping by the healthcare staff. Moreover, the healthcare personnel's narratives failed to comprehend that some emotional expressions of women in labour may have been a direct response to the personnel's behaviour, to the feeling of helplessness, fear, and the absence or loss of control over their own birth and body, to the violence that may have been committed on them during labour (even unconsciously, or driven by healthcare personnel's "good intentions"), or that it may have even been a symptom of the re-opening of earlier traumas.

The imbalance of power between healthcare personnel and women was also enhanced by various forms of depersonalisation or dehumanisation of the women (e.g., not addressing them by surname but by a universal "mom"; healthcare personnel entering the rooms without knocking and introducing themselves; in their own language, healthcare personnel "perform birth" on women instead of acknowledging the women's active role in giving birth; the symbolic appropriation of women and their bodies through language expressions that describe women as objects in the personnel's control; speaking about a woman in labour as if she was an instrument or an item which healthcare personnel "handle" or on which they perform certain actions). The failure to perceive a particular woman as an autonomous and individualised subject may then be one of the possible explanations for seeing the birthing woman as someone who has no rights (or is not "entitled" to certain rights), and/or as someone whose rights can legitimately be ignored and breached.

Medical Practices and Standards in Individual Birthing Facilities: Evidence-Based Medicine v. Eminence-Based Medicine

Evidence-based medicine (EBM) should be a key principle governing the provision of birth care. The concept of evidence-based medicine is defined as the integration of the best available scientific evidence, clinical practice, and patient's values, extended to include the assessment of the concrete clinical conditions of patients and the circumstances surrounding the provision of healthcare. Medical guidelines include recommendations and practices or procedures that describe different models and methods of care, interventions, their efficiency, and risks, taking into account the best available scientific evidence.

Slovakia has no nationwide guidelines on birth care in place that would have originated from the discussion of all stakeholders and that would be based on internationally accepted guidelines and evidence-based medicine. Such guidelines are also not in place at the level of individual birthing facilities. The strictly hierarchical system in which an attitude/opinion or a direct command from a superior may influence the method and rate regarding particular interventions (such as in the case of an obstetrics department head who ordered an episiotomy performed on 100 % of primiparous women) has a considerable impact on the procedures applied in healthcare facilities. This situation reinforces the actual power the heads of obstetrics departments or birth clinics (most department heads are men – women are very rare in these positions) have to decide about how healthcare is provided in their facilities. Thus, the term "evidence-based medicine" could perhaps be reconstituted

as "eminence-based medicine", i.e., medicine based on the beliefs of particular persons who, due to their position within the hierarchy of their institution, define healthcare procedures and practices to be applied at their workplaces.

The routine use of some practices is also influenced by custom and habits, that is, certain interventions still continue to be performed the way they "used to be performed" in the past, despite the existence of scientific evidence proving such interventions may actually be inappropriate or even harmful.

In order to understand the mechanism of replicating routine practices and procedures used in birthing facilities, one cannot overlook the system of education and training for healthcare personnel. In general, the interviewed doctors praised the theoretical knowledge they gained during university studies. However, universities do not provide practical training sufficient to prepare their graduates for practice in birthing facilities. Graduates of medical studies lack practical experience, unlike midwives whose studies involve a number of practical training opportunities. Practical experience and procedures applied by the healthcare personnel are to a large extent shaped and formed by the working team the health professionals join after they finish their university studies. Our research also indicates that experience obtained abroad or in a different hospital in Slovakia (in the form of practical training, internship, or work experience) has a greater impact on the broadening of the perspective in connection with the procedures normalised and routinely applied during births in Slovakia. However, even here the change in attitudes and a more critical view of the applied practices occur on an individual level and among junior personnel only, who do not have the real power to promote and push forward system-level changes. The lack of power to influence established practices is even more prominent in the case of midwives who can only afford to "polemise" over such practices with other midwives, but usually not with doctors.

The interviews with the doctors and midwives also show quite a visible generation gap between senior and junior personnel. The research has shown differences between these generations in the approach to established practices, and indicates that critical views of some of such established practices and procedures (or requests for implementation of the evidence-based medicine practices which are still insufficiently, or not at all, applied in Slovakia) prevail among younger, as yet uncertified doctors, as well as among junior midwives. However, generational differences alone have little to no potential to bring about crucial changes in the Slovak birth care system in the near or more distant future. The education that the next generations of doctors and midwives receive in this institutionalised system only replicates established procedures and practices, organisational culture and structures, and *de facto* normalises them for these next generations as well. Without elaborated interventions in the birth care system both at the nationwide level and at the level of individual hospitals, existing procedures are most likely to be preserved and continue replicating, though with some room for gradual change.

A number of factors contribute to the preservation of the routine application of some practices and procedures and often to their generalisation. These include: the setting of a birthing facility as an institution with hierarchically arranged rules of power; the absence of birth care guidelines following the knowledge of evidence-based medicine and internationally recognised medical standards; substituting procedures based on current scientific evidence with customary and habitual procedures; and the lack of understanding of the informed consent concept and other human rights among healthcare personnel. Although it is extremely difficult to retroactively assess whether particular interventions were performed for clinically indicated reasons or as a routine practice, the narratives of the healthcare personnel (as well as some statistics) indicate that these interventions are made routinely. The interviews with birthing women also imply that a general tendency to intervene in childbirth can be observed in hospitals. Considering these perspectives, the trend is obvious: interventions are used

in situations when they do not seem necessary or beneficial under the internationally recognised medical guidelines, or even when they are considered harmful.

This extensive use of interventions in childbirth is also driven by an effort to speed up births. The acceleration of labour (acceleration for acceleration's sake) appeared in various contexts in the research, although only two respondents openly spoke about this practice. Factors that accompany – or even cause – the routine use of interventions to speed up childbirths in Slovakia are, according to the interviewed respondents, especially system-level causes such as the lack of time, the lack of room in hospitals, the lack of healthcare personnel, and an overall effort to expedite deliveries, or a combination thereof. The speeding up of labour and delivery was often legitimised by a belief that it was being done "for the good of the women" or "preventively", etc., and that it represents an intervention generally beneficial to childbirth. However, the narratives of the healthcare personnel indicate a considerable difference between what they consider a standard duration of the pushing stage compared to what is considered normal by the internationally recognised medical guidelines. While international guidelines state that the normal duration of the pushing stage is between 1 and 3 hours, according to Slovak healthcare personnel this time is considerably shorter – 10 to 20 minutes.

The opportunity to move freely and change positions during the first and second stage of labour is especially important to women. Some internationally recognised medical guidelines recommend that birth attendants discourage women from lying on the back and encourage them to assume vertical positions, such as squatting, for instance. The supine position is associated with such risks as fetal distress, the need for instrumental vaginal delivery, and increased pain. Moreover, this position has no mechanical advantage to enhance fetal descent. Since the pushing stage may well last dozens of minutes during some childbirths, it is important that women experiment to find a position that will relieve their pain during labour. The change of positions is not only an effective method of pain relief, but it is also recommended as an intervention where labour is not progressing.[3] The freedom to choose positions is also one of the indicators of the quality of healthcare developed by international professional organisations.[4] By contrast, a Slovak university textbook on obstetrics care published in 2014 states that "[i]n a majority of our hospitals, the parturient is placed on a birthing table, lying on the back and with legs placed and fixed up in stirrups, which she is also holding with her hands while pushing."[5] The interviews with women also indicate that almost all of them delivered babies in the supine position; only one of them was allowed to take a different position. Frequent arguments given by the healthcare personnel for not allowing women to choose positions included "safety" (for

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[3] For more information on recommended approaches to freedom in position and movement throughout labour see, for example: FIGO Safe Motherhood and Newborn Health (SMNH) Committee: Management of the second stage of labor. In: *International Journal of Gynecology and Obstetrics*, vol. 119, 2012, pp 111 – 116. Available at: http://www.w3dezine.in/clients/fogsi/wp-content/uploads/2015/05/pdf/figo_guideline_management_of_the_ssl.pdf (last visited on 16 October 2016). *Intrapartum Care: Care of healthy women and their babies during childbirth. Clinical Guideline 90: Methods, evidence and recommendations*. London : National Collaborating Centre for Women's and Children's Health, 2014. Available at: https://www.nice.org.uk/guidance/cg190/evidence/full-guideline-appendices-ae-g-h-jr-pdf-248734766 (last visited on 11 October 2016). WORLD HEALTH ORGANIZATION: *Care in Normal Birth: a practical guide*. Geneva : World Health Organization, Department of Reproductive Health & Research, 1996, p 27. Available at: http://www.who.int/maternal_child_adolescent/documents/who_frh_msm_9624/en/ (last visited on 16 October 2016).

[4] FIGO, WHO, WRA, ICM, IPA: Mother-baby friendly birthing facilities. In: *International Journal of Gynecology and Obstetrics*, vol. 128, 2015, pp 95 – 99. Available at http://dx.doi.org/10.1016/j.ijgo.2014.10.013 (last visited on 28 October 2016).

[5] HOLOMÁŇ, K. a kol.: *Vybrané kapitoly z pôrodníctva* [Selected chapters from obstetrics]. Bratislava : Univerzita Komenského Bratislava, 2014, p 252.

example, they say they need to have "access to the woman", or they need to "protect the perineum"), missing "technical equipment" (though none of the interviewed made it clear what kind of "technical equipment" was missing in order for the healthcare personnel to enable delivery outside an obstetric chair), as well as the convenience and benefits for the healthcare personnel of the supine and semi-supine position of the woman in an obstetric chair. An argument based on the allegedly limited space in healthcare facilities was also mentioned during the interviews. However, one important fact that cannot be ignored is that the healthcare personnel mostly had no practical experience with attending to women labouring in other than the customary supine position (except for one male and one female obstetrician; both of them had previously worked abroad and had such experience). The interviews also showed that some obstetricians and midwives did not have sufficient theoretical knowledge regarding alternatives to the supine position discouraged by international guidelines, and that they could not imagine labour and delivery taking place in anything other than the supine position. Opinions differed among the interviewed healthcare personnel on the benefits of the freedom to choose positions during labour. Some of them considered the supine position beneficial, their main argument being better access to female genitals. However, we also heard an opinion that the supine position is harmful, and that women should definitely be encouraged to freely choose a position that suits them best. Some respondents said they would want to try to assist women giving birth in other than the supine or semi-supine positions.

Fundal pressure, the so-called Kristeller's expression, means applying pressure on the belly of a birthing woman by a member of the healthcare staff to speed up delivery. WHO claims that in addition to increasing women's discomfort, fundal pressure is suspected to have possible harmful effects on the uterus, perineum, and fetus. A Slovak university medical textbook also describes the use of the Kristeller's expression, i.e., "application of external fundal pressure", as a "*non-lege artis* practice" (i.e., an incorrect and illegal practice) that "increases [...] the risk of uterine rupture".[6] None of the recommendations contained in the international medical guidelines include any form of the application of pressure on a woman's belly during the second stage of labour. The interviewed women mentioned fundal pressure very often, saying that this practice was used routinely, even without their consent, and they described this intervention as extremely painful. There were some controversies about the use of this practice among the interviewed obstetricians and midwives, too. They knew it was harmful and had information about it, yet they used it routinely. Some of them differentiated between various applications of fundal pressure, describing the Kristeller's expression as an inappropriate practice harmful to women in labour. On the other hand, they defended using other forms of fundal pressure in what are, in their opinion, indicated cases. The interviews in particular showed that the healthcare personnel distinguished between a "prohibited" form of pressing on the belly (the so-called Kristeller's expression) when, for example, an elbow is used to exert a high pressure on the fundus, and a "permitted", moderate pressure ("fundal pressure" or "holding the fundus"). However, a clear-cut and explicit distinction between the "Kristeller's expression" and "fundal pressure" could not be drawn from their descriptions. It is very likely that the two terms were often used synonymously. Regardless, the interviews made it obvious that some sort of fundal pressure is used quite routinely, and the information provided by the midwives clearly shows that even the most harmful forms of fundal pressure are used in Slovak birthing facilities. This intervention is more often performed by midwives than doctors.

An episiotomy is a surgical incision made in the area between the vagina and anus (perineum). This is done during the last stages of labour and delivery to expand the opening of the vagina.

[6] *Ibid.*

In the past, the episiotomy was perceived as protecting against severe perineal and rectal tears. A 2014 Slovak university medical textbook still describes this intervention as a method of protecting the perineum against rupture (tear). However, extensive studies and research have disproved these theories and even evidenced that a policy of restricted episiotomy results in a lower risk of serious perineal and rectal injuries when compared to a policy of routine episiotomy. Professional guidelines require that an episiotomy should only be done when clinically necessary, for example, in the case of an instrumental delivery or if the life of the fetus is at risk. WHO recommends that the episiotomy rate should be not higher than 10 %. Several of the women who participated in our 2014 research had requested in their birth plans, or during consultations with an obstetrician, not to have an episiotomy. Nevertheless, most of them had had an episiotomy, performed without their prior consent – or, in some cases, even without their knowledge. Episiotomies were the most discussed interventions during the interviews with the healthcare personnel and their views considerably differed. First, a majority of interviewed obstetricians defended the use of this intervention when they thought it was implemented on indication, and all of them claimed they did not practice routine episiotomies. During more detailed discussions, however, they admitted that the episiotomy rates are in fact quite high, and that they are performed routinely as a preventive measure or to expedite delivery, even when unnecessary. Frequent arguments in favour of episiotomy also included the protection of rectum against ruptures and easier healing and suturing. However, these arguments have no support in evidence-based medicine.

Oxytocin is a hormone that the body naturally produces during childbirth. In addition to its numerous other effects, oxytocin causes uterine contractions during the second stage of labour. In its synthetic form, oxytocin is used to boost uterine contractions and may be administered at all stages of labour. According to WHO, oxytocin augmentation is a major intervention in childbirth and, therefore, should only be implemented in the case of a serious indication.[7] As all other interventions, the administering of oxytocin is also conditional upon the informed consent of the labouring woman. Several women said during the interviews that they had been administered synthetic oxytocin during childbirth through an intravenous cannula routinely inserted in advance. In most cases, however, the women were not informed about this intervention in advance and were not asked to provide informed consent. Some of them were told about the use of oxytocin only afterwards. The use of oxytocin augmentation was generally described as a routine practice. The responses from the interviewed medical staff also imply the excessive use of synthetic oxytocin in Slovak childbirth facilities. The time factor was often used as an argument in favour of the use of synthetic oxytocin as it expedites labour. However, internationally recognised guidelines do not recommend the routine use of oxytocin to shorten the duration of labour because the active management of the first stage of labour (i.e., when the cervix dilates) is more painful to women. In addition, studies found no evidence showing that the use of oxytocin considerably shortens labour. The healthcare personnel's arguments in favour of oxytocin augmentation again explicitly included non-medical reasons, such as being implemented "for the mother's own good" or "to shorten suffering", etc. This generally implies that the use of synthetic oxytocin is often justified by other than strictly medical criteria.

Safety and risk prevention were among the reasons given by the healthcare personnel for the routine prophylactic insertion of an intravenous cannula in the case of each woman. In some instances, the

[7] WORLD HEALTH ORGANIZATION: *Care in Normal Birth: a practical guide*. Geneva : World Health Organization, Department of Reproductive Health & Research, 1996, p 23. Available at: http://www.who.int/maternal_child_adolescent/documents/who_frh_msm_9624/en/ (last visited on 16 October 2016).

healthcare personnel admitted that this practice was driven by systemic motives: the lack of staff. The interviews with the women implied that the insertion of a cannula "just to be sure" had been an "invitation" to administering medications without the women's consent and often even without their knowledge.

Further examples of routine practices include the shaving of pubic hair or the use of enema, which also conflicts with internationally recognised medical guidelines. This was where the opinions and experience of the interviewed healthcare personnel differed the most. While staff in some Slovak childbirth facilities could not imagine childbirth without enema and shaving, other facilities in the country left decision-making on these aspects to women. However, the freedom of choice may only be ostensible in this respect. In some narratives, it became apparent that the personnel sought to persuade women to agree to an enema by manipulating or embarrassing them.

None of the respondents from the ranks of the healthcare personnel directly expressed that they are required, or feel it necessary, to continuously follow the most recent scientific progress and developments related to birth care. At the same time, they often apply outdated and obsolete knowledge and practices, though it is the healthcare personnel who should be the agents of change when it comes to introducing and implementing the most recent scientific knowledge and best practices, and who should be responsible for putting such methods into practice.

Organisation of Work in Birthing Facilities and Status of Midwives

In many countries, women are accompanied throughout the entire childbirth mainly by midwives who provide continuous care and support. Obstetricians are only summoned if complications occur. In these countries, midwives are considered competent in assisting women during the entire physiological childbirth, their competencies also including an ability to recognise when an uncomplicated childbirth begins to turn pathological where an obstetrician with expertise to address complications during birth must be engaged.

Obstetrics care in Slovakia was also originally provided by female attendants – midwives. The socialist reform of the healthcare system gradually enhanced the position of gynecologists and obstetricians, and consequently, midwives transformed into nurses, subordinated to doctors within the healthcare hierarchy. In fact, midwives continue to be subordinated to doctors, irrespective of the amount of practical experience of either party.

Some of the interviewed midwives presented a critical view of their current position within their working team. Even though they understand their role as "being of assistance", their view of this role is that they assist doctors, not directly the women in labour. Formally, legislation allows midwives to assist women during physiological childbirth (including when an episiotomy is needed)[8] on their own, but, in fact, they cannot actively assist labouring women alone or take any action if they disagree with an intervention performed by a doctor.

This hierarchy is then also reflected in decision-making processes, including during childbirth, and is demonstrated in conflicts of power between doctors and midwives. Even though cooperation between obstetricians and midwives is inevitable, midwives often feel their work is underrated. Some of the

[8] See Decree No. 364/2005 Coll. of the Ministry of Health of the Slovak Republic laying down the scope of nursing practice provided by the nurse independently and in cooperation with a physician and the scope of childbirth assistance provided by the midwife independently and in cooperation with a physician, Section 4(3)(f).

interviewed midwives emphasised that they felt they had an unequal relationship with obstetricians. They are not even invited to regular consultations concerning individual women or informed about their possible complications. Despite their current position within the medical staff hierarchy, midwives continue to be the personnel spending the most time with women during childbirth.

Midwives have a good number of tasks and responsibilities to attend to, and our research data also indicate they are overburdened by their official duties. Their duties often include a great deal of administrative work, additional assignments in a gynecological office and then in the obstetrics department, as well as activities for which they are over-qualified. Frequent overburdening at work and cases of "burnouts" among midwives may well be caused by the small numbers of midwives on staff in Slovak birthing facilities. Many of the interviewed obstetricians admitted that midwives have to work very hard and are underpaid, which in turn results in their profession being less attractive as a career choice to young women. As suggested by the healthcare personnel during the interviews, one of the possible solutions for improving this situation with respect to the current status and overburdening of midwives – and to enhance the quality of care provided to labouring women as well – is to restore and reinforce the role midwives play during physiological childbirth, allowing them to actively and independently assist labouring women. However, opinions of and discussion on the tasks of midwives during childbirth were not clear-cut. Some of the midwives refused to accept the active role of primary and autonomous care provider to women during physiological childbirth out of the fear of both the potential problems that can arise during birth as well as accepting the increased responsibility that would go hand-in-hand with the increased autonomy. Although the respondents did not specify these potential problems during the interviews, we can generally conclude that in a system of birth care where midwives' capacities are consistently overloaded, the transfer of competencies and responsibilities from obstetricians to midwives must also include guarantees that would enable midwives to effectively perform these responsibilities in practice, both in terms of necessary capacities as well as in terms of sufficient professional and practical training, systematic supervision, and adequate remuneration. Another prerequisite of the effective transfer of responsibilities to midwives is, beyond a doubt, to have clearly defined responsibilities at particular workplaces and in particular cases. The nonexistence of such defined responsibilities, especially where guidelines on the provision of birth care are missing (at the national level, as well as at the level of individual hospitals), may also represent a real barrier for midwives to effectively assume and bear responsibility.

Healthcare Personnel's Reflection on the Provision of Birth Care: Changes Needed, Strengths, and Agents of Future Change

The interviewed obstetricians and midwives agreed that there are some aspects in the current system of birth care that require a change. The lack of healthcare personnel and understaffed birthing facilities were clearly the main issues criticised by the respondents. They also said some devices, or technical equipment in general, should be replaced or replenished. At the same time, the respondents were critical where hospitals did not offer "extra standard" services and sufficient protection of privacy. However, they did not realize that these "extra standard services" only covered the basal requirements for the fulfilment of women's fundamental human rights – namely the right to privacy and intimacy, the right to quality and acceptable healthcare, the right to decide on the circumstances of childbirth, and the right to human dignity in general. Some respondents indicated that they might appreciate the women being given the opportunity to give birth in positions of their choosing and to have a partner present throughout the entire process of childbirth (including during caesarean sections).

Many obstetricians recognised conflicts between approaches based on the previous generation of medical procedures and knowledge, where the system of birth care has an authoritative relationship to birthing women, and approaches based on the respect to birthing women. Several of the obstetricians reflected both on the un-empathetic behaviour of some of the healthcare personnel towards birthing women and on the style of communication used by the healthcare personnel that did not present the women as equals, as well as on the relationships in the healthcare system not being organised on the basis of equality, which results in mutual mistrust between healthcare personnel and women, and admitted that the criticism posed by women is fully legitimate. Among the changes that should be adopted, these obstetricians suggested establishing standards where personnel should introduce themselves, engage in adequate communication, make information available to women, and provide an individualised approach to each birthing woman.

Two obstetricians (one female and one male) suggested that women themselves should increase pressure in order to implement change. In their opinion, only pressure exerted "from the bottom up" can help women to be heard and have their needs considered in the existing institutional setting. Although it is completely legitimate for women to express their wishes and needs, to criticise the current system, and to make attempts to change it "from the bottom up", the position of women within this system, their opportunities, and the scope of their responsibility for the change need to be assessed in a wider context. For example, the obstetricians completely failed to reflect upon the hierarchical setting of the obstetrics care system with respect to women, the fact that women are especially vulnerable during pregnancy – and during childbirth in particular – and other gender-specific aspects of the Slovak birth care system. It is also important to keep in mind that the responsibility for the fulfilment of human rights is borne by the state and individual care providers and that these providers should not simply wait until women win these rights on their own.

How to Grasp the Challenge, or Key Principles in the Change Process

Slovak birthing facilities are patriarchal institutions with hierarchically arranged rules and relationships of authority and power, often employing monocratic decision-making governing the provision of birth care. There are no birth care guidelines in place that would correspond with the knowledge ensuing from evidence-based medicine and internationally recognised standards of care. Therefore, childbirth facilities in Slovakia apply outdated and obsolete practices and procedures, often performed routinely and "across the board".

Obstetricians and midwives are not familiar enough with the concept of informed consent, that is, they fail to properly understand that, pursuant to the applicable legislation, decisions concerning the performing of individual healthcare interventions should ultimately be made by women themselves, not by the healthcare personnel.

In response to our findings presented in this publication, we wish to inspire debate on women's human rights in childbirth among professionals and experts and the wider public, which we believe will help design a birth care system primarily driven by the needs of women and their children, a system that will respect, protect, and fulfil their human rights at all levels.

In order to accomplish this goal, a wide range of elaborated, mutually overlapping and complementing measures will need to be implemented simultaneously. One such measure might be to develop and regularly update guidelines on birth care that align with evidence-based medicine and human rights

principles. These guidelines should be adopted on a nationwide level and supplemented by regular monitoring and audits performed across all birth care facilities in Slovakia. The monitoring should also involve continuous feedback obtained directly from women.

Human rights education, with a particular focus on women's human rights and reproductive rights, should be made part of both university education and the continuing education and training of healthcare personnel. Much attention should be paid to the concept of informed consent, or informed decision-making that women are entitled to, and to its application in practice. The education of health professionals must also include gender sensitisation and training focused on empathic and effective ways of communication, including communication in emergency or other stressful situations. Healthcare personnel should also be given both theoretical and practical training on the methods of birth assistance as yet unknown to them but recommended by internationally recognised medical guidelines (for example, assisting with different birthing positions).

In addition, changes will have to be made in the organisation of workflow in birthing facilities – in terms of the division of tasks and responsibilities among the individual members of the healthcare personnel and in terms of management of work hours, as well as in terms of personnel capacities. Birthing facilities will need to be redesigned to be able to enhance the protection of women's privacy and intimacy, and equipped with the necessary materials, resources, and technologies so as to allow the healthcare personnel to perform relevant professional duties in line with evidence-based medicine.

All of these changes must be designed and implemented under the equal and democratic participation of all stakeholder groups, including midwives and, in particular, women themselves. The red thread to be followed in all discussions, processes, and changes must be an unconditional effort to centralise birth care around birthing women and their newborn babies. This will also require the complete recasting of the concept of "safety" as it is currently understood by the obstetricians – i.e., as an objective practice in which a living and (relatively) healthy baby is born to a living and (relatively) healthy woman, while healthcare personnel also have the capability to intervene when they identify pathologies – toward a concept of safety that must also incorporate the notion of women feeling safe, and reflect the long-term impacts of birth care on rights, and physical and mental health.

It is evident in this context that the necessary changes and the outlined and other necessary processes cannot be implemented without a sufficient volume of quality data (both quantitative and qualitative), which must be collected primarily by the state, its bodies, and public institutions, as well as by individual healthcare facilities. The existence of such data can facilitate a situation where the making of decisions is not based on the impressions and feelings of the official authorities in control of the birth care system, but which will reflect (including as yet unrecognised) facts and contexts.

None of the necessary changes can be made without sufficient resources, including financial and human. Investing these resources might likely pay off quickly for us all – bringing about both economic benefits and social progress.

www.odz.sk/en/
www.diskriminacia.sk/en/

Občan, demokracia a zodpovednosť (ODZ) (Citizen, Democracy and Accountability) is a human-rights non-governmental organisation with more than 20 years of experience. One of its main aims is to promote the rights to human dignity and the protection against discrimination, and especially the assertion of the human rights of women, including reproductive rights. In accordance with its mission, the organisation is focused on advocacy and litigation, as well as educational activities and monitoring. In its work, it strives for positive changes in society with the aim of contributing to the fulfilment of the principle of the rule of law and the accountability of public authorities at all levels. Therefore, in the areas of its activity, the organisation is involved in public policy-making and setting policy processes, as well as monitoring implementation and compliance with human rights obligations.

www.zenskekruhy.sk

Ženské kruhy (Women's Circles) is a human rights non-governmental organisation founded as a women's civic initiative in 2011, with the goal of changing the state of healthcare for women with regard to pregnancy, birth, and puerperium. Within its mission, the organisation performs community, advocacy, and research activities. Activities are focused mainly on disseminating information concerning respectful maternity care and women's rights in childbirth.

Women – Mothers – Bodies II: Systemic Aspects of Violations of Women's Human Rights in Birth Care Provided in Healthcare Facilities in Slovakia is a second publication jointly released by Slovak NGOs Občan, demokracia a zodpovednosť (Citizen, Democracy and Accountability) and Ženské kruhy (Women's Circles) as a result of their long-term cooperation. The book is a sequel to ***Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia*** that gave pilot insights into the violations of women's human rights in Slovak birthing facilities from the perspective of women as rights holders.

The first publication of the ***Women – Mothers – Bodies*** series, based on internationally recognised human rights standards and medical guidelines, has so far been the only publication of its kind in Slovakia to elicit a due response and raise awareness of the issue of women's human rights in childbirth. In addition to the media, women, non-governmental organisations, and international institutions, the publication also drew the attention of healthcare personnel, in particular obstetricians and midwives. During more or less formal discussions (though largely ignored by the Slovak Ministry of Health), the stakeholders basically agreed on one thing: a qualitative shift in the provision of birth care in Slovakia towards respecting women's human rights is impossible without extensive system-level changes to remove the causes of existing human rights violations.

The ***Women – Mothers – Bodies II*** publication, the summary of which you now have in hand, seeks to describe some of these causes and various other system-level aspects related to the violations of women's human rights in Slovak birthing facilities. To identify these causes, a series of in-depth interviews with obstetricians and midwives proved to be an important source of information. On the one hand, these professionals are confronted on a day-to-day basis with the system of the institutionalised provision of birth care from within; on the other hand, they, at the same time, represent and create this system. The present publication focuses on various factors affecting the way birth care is provided and the quality of such care, while understanding these factors in their cultural context and from a wider social perspective as well. For example, the publication focuses on the institutional and organisational setting of birthing facilities and hierarchical arrangements of power and authority within them; on decision-making mechanisms regarding how care is to be provided in a particular case; on the mechanisms preserving the status quo; on personal and other resources, including hospital equipment; and also on how obstetricians and midwives are trained, or how they perceive women giving birth.

In a number of places, the publication compares and confronts the views and opinions of healthcare personnel and women. Even though interpretations and reflections on several aspects in the provision of birth care are diametrically different between these two groups, they all agree that the Slovak system of birth care is seriously flawed. The publication may, therefore, serve as a good starting point for further discussion on these shortcomings in order to seek and find solutions to drive the Slovak birth care system towards one where care is provided in line with women's rights.

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ŽENSKÉ KRUHY