AIMS For a better birth...

Reproductive justice

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Jo Murphy-Lawless raises awareness of the situation for women in Ireland

In a wide-ranging article by social policy analysts on women's reproductive needs in all their dimensions, Zakiya Luna and Kristen Luker have put forward this definition of reproductive justice, taken from an action group in the United States,Asian Communities for Reproductive Justice:

'the complete physical, mental, spiritual, political, economic, and social well-being of women and girls [that] will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives'[1]

If all women, regardless of class, body shape, mental health status, ethnicity, and citizenship, immigration status (just to mention some of the ways whereby pregnant women suffer discrimination), were to have such scope over their needs in relation to pregnancy and birth, we would see a true revolution in maternal wellbeing and in social justice. That revolution would centre above all on an impeccable quality of care, attention, and responsiveness given to women within our maternity services as a matter of course.

In Ireland, at the end of 2016 we have reason to think about this definition with considerable sadness and dismay, and not a little determination to throw ourselves back in to the struggle to give it substance. The last week in October this year saw the publication of the Economic and Social Research instituite, (ESRI) report on the current national rate of caesareans, and then 28 October, was the fourth anniversary of the death of Savita Halappanavar.

Lessons learned?

I want to turn first to Savita Halappananvar's tragic and completely avoidable death in 2012, see AIMS Journal Vol:25 No:2 2013, p14-15. If her inevitable miscarriage had been dealt with appropriately, on the Sunday when she was admitted to Galway University Hospital Savita would have lived despite her ordeal. Blood tests which already showed a raised blood cell count should have been appropriately reported back on and followed through with a termination which was her request. The blood tests never found their way back to the ward and her request for a termination was met with a stony-faced response about the cruel Eighth Amendment to the Irish constitution, which gives equal right to life of the unborn fetus. This amendment, still not overturned despite numerous actions within Irish courts and within the European Court of Human Rights, has insinuated its way into women's maternity care straight across the

board and is enshrined in the national consent policy of the Health Services Executive (HSE) which has responsibility for the running of the Irish health services.

Of the official reports which followed Savita's death, the most important was that published by HIQA, the national Health Information and Quality Authority which discussed the thirteen occasions where staff failed to act to prevent Savita's dying and said in starkest possible terms that Irish maternity services were failing to provide uniform care of the best possible quality and that a national review was urgently meeded.[2]

More rhetoric, no substance, no change

That review process finally began in 2015 and the National Maternity Strategy which was the outcome of the review committee was published in 2016.[3] The strategy, entitled 'Creating a Better Future Together', is a major disappointment. Stamped all over it is the mark of the struggle between the midwives who fought for a clear evidence base on which to finally develop Irish maternity services appropriately, including the expansion of midwifery-led units around the country (there are still only in existence, the original pilot midwifery-led schemes established in 2005 in Cavan General Hospital and in Our Lady of Lourdes Hospital Drogheda) and Irish obstetricians. The latter will not let go of their power base and continue to be fixated with their entirely inadequate understanding of the term 'risk' and their professional control to set and define the parameters of what 'risk' might constitute.

There are two key statements which expose this thinking in the Strategy's introductory comments:

... that this new 'service' is a 'maternity service that facilitates choice, yet has all the necessary safety assurance.[3]

Yet again the implication and the drift are that women may make 'choices' but that their choices need to be 'safe' with the decision-making on safety being in the hands of the clinicians, not the woman. This is a million miles removed from the ethos of the Albany, for just one sterling example, where the woman was the primary decision-maker in partnership with her midwife.[4]

The second longer comment is, if anything, a more disquieting use of rhetoric:

'At the centre of this Strategy is the mother. We have therefore avoided, as far as possible, profession-centric terms such as "consultant led" and "midwifery led", as they incorrectly place an emphasis on the profession' [3]

This neatly dumps overboard a decade and more of consistently outstanding international research on the central importance of the midwife-mother relationship and its connection to best possible physical, psychological and social outcomes for a new mother and her baby.

The strategy continues to valorise the clinically ascribed risk status of women within the narrowest possible parameters:

A woman's risk status will be determined by clinicians led by obstetric 'guidelines'.

Women whose pregnancies are deemed 'normal' will still require 'permission' to give birth in an alongside midwifery-led unit.

Women who are deemed 'medium' or 'high risk' will have no additional latitude in where they give birth than now: it will be in an obstetric consultant-led unit.

As the commentator Jacky Jones wrote, after waiting 60 years for a new maternity strategy, we have got one which continues to see women's bodies as 'defective and dysfunctional' and where the Eighth Amendment absolutely limits women's decision-making autonomy.[5]

Since the report's launch on 5 January 2016, and despite a spate of probing questions in the Dáil by the Independent Right 4 Change socialist TD Deputy Clare Daly, there is no indication when this strategy will actually begin to be implemented in any concrete way. All we have gathered is that a mere three million euro budget has been set aside for its implementation.

Safe? How safe?

The three million budget will not even begin to cover the desperate problems created by shortfalls in staffing which themselves follow on decades of neglect of the maternity services exacerbated by the economic collapse of 2008-2010. A recent parliamentary question submitted by Deputy Daly emerged with the information that this understaffing of midwives alone amounts to a 17 percent shortfall or 35 fulltime equivalent midwives in the Coombe Women and Infants University Hospital and 42 in the Rotunda Hospital.[6] These two hospitals are handling over 8,000 births each calendar year.

The lack of basic safety is glaringly obvious in these figures as are the pressures on staff and may account for the ESRI conference on increasing rates of caesareans to 30 percent nationally in the most recent year available, 2014.[7] While recently presented research calls attention to the rising age of first-time mothers and suggests that increasing complexity leads to more caesareans, the inability to staff labour wards to proper levels certainly plays a part as the ESRI summarises: *'However, funding and staffing levels in maternity services has not kept pace with either the number of births or the risk profile'*[7]

In the meanwhile we have had two high-profile maternal deaths in 2016[8] and two more babies' deaths during May in the already troubled Cavan General Hospital.[9]

Getting to reproductive justice

The Picking Up the Threads exhibition, drawing attention to the women who have died with our quilt (contributed to substantially by AIMS members) and our documentary, has been touring the country and drawing attention to the need for automatic inquests for maternal deaths. We are also drawing attention to the broader and very impacted problems with the maternity services: if we summarise these as understaffing, poor quality evidence, and poor professional support, we must also add that these services continue a tradition of state-backed patriarchy in Ireland which has consistently disadvantaged women's

voices, needs and lives.

So the other good news is that more recently qualified midwives are finding their voices and have been active in setting up two new groups, Midwives for Choice in Ireland and the Irish Midwives Association.

Tiny though these three efforts are measured against the all the work there is to do, we have at least a firm understanding of what reproductive justice comprises and how badly we need it in Ireland.

References

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