

Submission from Israel on the subject of mistreatment and violence against women during reproductive health care, with a focus on childbirth

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1. Executive Summary

In this submission to the United Nations Special Rapporteur on violence against women, we provide a review of the current state of affairs in the Israeli context pertaining to mistreatment and violence against women in reproductive health care, with a focus on childbirth.

First, we outline the legal framework in place protecting patients in Israel. We then provide background on the Israeli health care system relating to the subject at hand. Next, we present the available data in Israel from various sources, including complaints that have reached our hotline, survey responses, information provided by related organizations, and academic research. We then characterize the public discourse regarding this phenomenon, to give context both to the institutional responses, and to the accounts of women reaching our hotline. The near absence of this type of violence from Israeli public discourse explains some of the difficulties women encounter when attempting to share what they have experienced, let alone file a formal report.

Next, we present institutional practices designed to maintain patient rights, and discuss their limitations. We also refer to existing accountability measures. We move on to review past responses from the authorities to complaints about mistreatment and violence in reproductive care settings. Restrictions on alternatives to hospital births will also be considered. Finally, we examine the barriers to legal redress faced by women whose rights have been violated during reproductive health care, and specifically during childbirth.

To conclude, we propose a multipronged approach to preventing this type of violence. We advocate for raising awareness among the general public; implementing ongoing in-depth training programs for medical staff, regarding issues such as compassion fatigue, secondary trauma, and human rights during reproductive care; allocating adequate resources for maternity related departments; and putting in place clear accountability measures to ensure patients' rights are respected in this vulnerable time of their lives.

We hope these brief comments assist the Special Rapporteur in the preparation of her thematic report to the Human Rights Council on mistreatment and violence against women during reproductive health care.

2. About Women Call for Birth

Women Call for Birth (WCB) is an Israeli advocacy group that works to maintain the human rights of women during prenatal, childbirth, and postpartum care. Founded as a non-profit organization (NPO) in 2004, WCB serves as an umbrella organization for various initiatives advocating for reproductive health rights relating to birth. It aims to promote the view of childbirth as a natural physiological process, endorse evidence-based care for women and newborns, establish a public discourse recognizing the existence of obstetric violence, provide support and resources for women whose rights have been violated, and ensure every woman's right to choose the terms and setting of her birth.

Our activity is focused on raising awareness of human rights in childbirth among women, health care systems, and the general public, as well as developing alternatives to the current reality in the field. The organization is run with minimal funding by volunteers of different backgrounds who are passionate for the cause.

Our work involves conducting surveys, examining policies and guidelines in view of recent research, advocating for data transparency from medical institutions, attending parliament and ethics committees related to the field, promoting a rights based discourse of birth related issues in the media, and running a hotline for women who have experienced obstetric violence. We work in collaboration with midwifery and patient organizations, as well as other NPOs promoting women's health and childbirth issues.

Recently, our activity has led to the publication of partial birth and intervention rates data by public hospitals. In addition, we are currently involved in an ongoing appeal to the Supreme Court for the legalization of birth centers in Israel, following the closure of a practicing birth center by the Ministry of Health (MoH). We have also contributed to a recently published committee opinion of the National Committee of Bioethics regarding freedom of choice and human rights in birth.

We believe that every woman should be able to freely choose how, where, and with whom to give birth, while having all the relevant evidence-based information at her disposal. Every woman has the right to receive optimal reproductive health care and support during childbirth, in a manner that fully respects her choices. Reproduction and childbirth related choices are inherently related to women's autonomy of their bodies, their intimate life, their right to privacy and their human dignity. As such, violating the human rights of women in health care settings may have severe consequences and may cause harm to both women and their families.

3. Legal Framework of Patient Rights in Israel

There are several legal provisions in the Israeli law protecting the rights of patients. Since 1996, patient rights have been protected by The Patient's Rights Act, intended "to determine the rights of a person who seeks medical treatment or receives medical treatment and to protect his dignity and privacy"¹. The principles of the law are derived from the Basic Law:

¹ Israel: Patient's Rights Act, 1996, May 1, section (1).

Human Dignity and Liberty, which states that “there shall be no violation of the life, body, or dignity of any person as such”². Although many of the law’s principles have guided medical practice prior to the law’s enactment, this was the first time they have been explicitly anchored in legislation, enabling patients whose rights have been violated to seek redress in a court of law.

According to Israeli tort law, a care provider could be deemed negligent if they failed to obtain the patient’s informed consent prior to treatment³. Provision of treatment without informed consent can also be considered battery⁴. However, section 8 states that a defense may arise to the defendant if 'he committed the act in good faith where he had reason to believe it to be for the benefit of the plaintiff though was unable to obtain the consent of the plaintiff before doing such an act...'⁵.

In the landmark case of *Daaka vs. Carmel Hospital*, a woman was hospitalized for surgery on her leg⁶. Two days later, while she was in the operating room, a biopsy was performed on her shoulder. Following the operation, the appellant's shoulder remained frozen and a disability was determined. The doctors did not explain to the woman the need for the biopsy. The court ruled that no causal connection was proven and therefore the appellant is not entitled to compensation for the bodily harm caused to her. However, the court went on to state that infringement of the right to autonomy as in the provision of medical treatment without consent is compensable as a separate head of damage. Accordingly, she was awarded compensation for this violation alone.

A full legal analysis of the tort law in Israel relating to patient rights is beyond the scope of this report. Therefore, in this section we will review the main aspects of The Patient Rights Act-1996 relevant to women’s rights during reproductive health care.

The main principles of the law relate to the right to medical care, prohibition of discrimination, proper care, the dignity and privacy of patients, informed consent, access to medical information, confidentiality, documentation requirements, and accountability measures. It should be noted that the MoH has clearly stated that this law applies to all patients, including women during labor and delivery⁷.

According to the law, every person in need of medical treatment is entitled to adequate medical care, whether as routine care or in an emergency, without any conditions placed on provision of treatment. A patient is entitled to information about the identity and role of any person who is treating him or her, as well as to receive an additional opinion regarding his or her treatment. A patient has the right to change a caregiver or even a medical institution, with the cooperation of the former caregiver or institution, in order to ensure proper care. All employees of the medical institution shall maintain the dignity and privacy of the patient at all stages of the medical treatment. The law goes on to state that instructions for maintaining

² Israel: Basic Law of 1992, Human Dignity and Liberty, 1992, March 25, Section 2.

³ Torts Ordinance [New Version], section 35.

⁴ Torts Ordinance [New Version], section 24.

⁵ Torts Ordinance [New Version], section 24, section 8.

⁶ Civil Appeal 2781/93 Daaka v. Carmel Hospital IsrSC 53(4) 526 (1999)

⁷ Knesset Research and Information Center. (2015). *Issues relating to the protection of the rights and privacy of birthing women in hospitals*, Israel, p. 13

the dignity and privacy of patients are to be set by the head of the medical center (Section 10b).

The issue of informed consent is discussed in detail in sections 13 through 15. In order to obtain informed consent, the clinician must first provide the patient with the medical information required to decide whether to accept the proposed treatment. The definition of the medical information required for the patient has been extensively addressed in court rulings. In a case considered by the High Court of Justice, it was given a broad interpretation which includes treatment or testing options that are not provided by the medical center itself⁸.

Written consent is required for procedures such as surgery (except for minor surgery), catheterization, dialysis, radiotherapy, in vitro fertilization, and chemotherapy. In other cases, it is possible to obtain consent via verbal interaction or behavior. The patient may appoint a representative in advance who will make the decisions regarding the proposed medical treatment.

Sections 15(1) and 15(2) pertain to medical care without consent. According to section 15(1), health care providers can treat a person without obtaining informed consent, if all the following conditions are met: the patient's physical or mental state does not permit obtaining his or her informed consent; the clinician is not aware that the patient or his or her legal guardian object to his/her receiving medical treatment; and it is impossible to obtain the consent of the patient's representative or the patient's legal guardian, where the patient is a minor or an incapacitated person.

According to section 15(2), in cases where the patient is deemed to be in extreme danger, health care providers may treat a patient against the patient's will if the following conditions are met: the patient has received information as required to make an informed choice; the treatment is anticipated to significantly improve the patient's medical condition; and there are reasonable grounds to assume that, after receiving treatment, the patient will give his or her retroactive consent. This treatment shall be given with the consent of three physicians, unless the emergency circumstances do not permit this.

Furthermore, the law defines three types of committees to be established for supervision of the implementation of the law: a committee of inquiry, a quality control committee, and an ethics committee.

In summary, The Patient Rights Act of 1996, anchored in the Basic Law: Human Dignity and Liberty of 1992, clarifies the meaning of human dignity in the context of medical care. It also defines several mechanisms in order to protect it. As stated by the MoH, the law pertains to all patients, including women in labor and delivery. However, despite many progressive sections of this law, it may leave significant room for interpretation. This is especially true in the case of childbirth, which is often considered to be an emergency by medical professionals. In addition, in practice there is a lack of enforcement of some of the rights specified in the law. Finally, in section 12, we will elaborate on the host of barriers women face when considering filing a formal complaint or lawsuit.

⁸ Civil Appeal 2124/12, Clalit Health Services v. A (2014)

4. Background of Childbirth and Reproductive Health Care in Israel

Based on data published by the Israeli Central Bureau of Statistics, there are approximately 180,000 births in Israel per year, the highest number of births of all OECD countries in relation to population⁹. In other words, every 3 minutes a new baby is born and every 18 minutes a caesarean section is being performed. The vast majority of these births take place in one of the 27 public or semi-private hospitals in the country providing labor and delivery services.

Israeli health care services are provided by law to all citizens, including birth related care. Every Israeli citizen is obliged to join a Health Maintenance Organization (HMO). As such, women can choose the gynecologist who will provide pregnancy tracking, both from within the HMO or as private care. Based on this model, pregnancy tracking is provided jointly by the community gynecologist and nurses, typically the same team for pre- and post-partum care.

As for the labor itself, women can choose the hospital, however, they are not familiar with the hospital staff nor do they have any choice regarding specific health providers within the hospital. Only two centers allow a private staff during birth itself, but this option is costly, relatively unknown, and comprises an insignificant portion of births in Israel. At the same time, the high number of births in Israel creates an immense work overload for midwives in facility-based units. They are responsible, on average, for 2 or 3 laboring women simultaneously. This issue has been raised in the media and the parliament (Knesset) by both physicians and the Israeli Midwives Association in Israel¹⁰.

Therefore, apart from home births, there is currently no model of care which offers continuous care by the same health care providers before, during and after birth, nor is there a model of one-to-one care during labor. This is despite the fact that research supports the positive impact of such models on childbirth, with reduced rates of interventions and morbidity¹¹.

It should be noted that out of the 27 medical centers around the country providing labor and delivery services, about half have dedicated one or two rooms to natural childbirth. However, the privilege of using these rooms is granted only to women who comply with criteria that define them as low-risk pregnancies. If any intervention is requested or required, women are then transferred to a 'standard' birthing room. Given the overload on facility-based centers, the option to give birth in a dedicated natural birth room is viable based on chance availability, as well as the availability of trained staff on duty, which is not guaranteed.

⁹ Israeli Society of Maternal-Fetal Medicine (2016). *Obstetrics in Israel: Annual Report of 2016*. Israel

¹⁰ Israel Midwives Association (2014). *Beginning the Fight for Midwife Staffing Ratio*. Retrieved from: <http://www.midwivesil.co.il/?CategoryID=176&ArticleID=452>

¹¹ Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2013). Continuous support for women during childbirth. *Cochrane database of systematic reviews*, (7), Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane database of systematic reviews*, (4).

In the current situation, the vast majority of births occur in medical centers. The MoH policy has been highly restrictive of out-of-hospital birth, applying a stringent home birth guideline, closing all freestanding birth centers by declaring them illegal¹², and providing no subsidies for home birth midwives' care nor professional insurance for home birth midwives. This matter will be further developed in section 10.

5. Available Data related to Mistreatment and Abuse in Childbirth and Reproductive Health Care in Israel

5.1 Childbirth related National Data and Statistics

As mentioned above, each year approximately 180 thousand births take place within 27 labor and delivery units in Israel. Every year, the Israeli Society of Maternal and Fetal Health publishes a report presenting the average rates of interventions performed during childbirth. It also includes the lowest and highest rates of interventions found in Israeli hospitals. However, it does not disclose the names of the hospitals nor does it attempt to explain the wide range of intervention rates between the different facilities (see Figure 1)¹³.

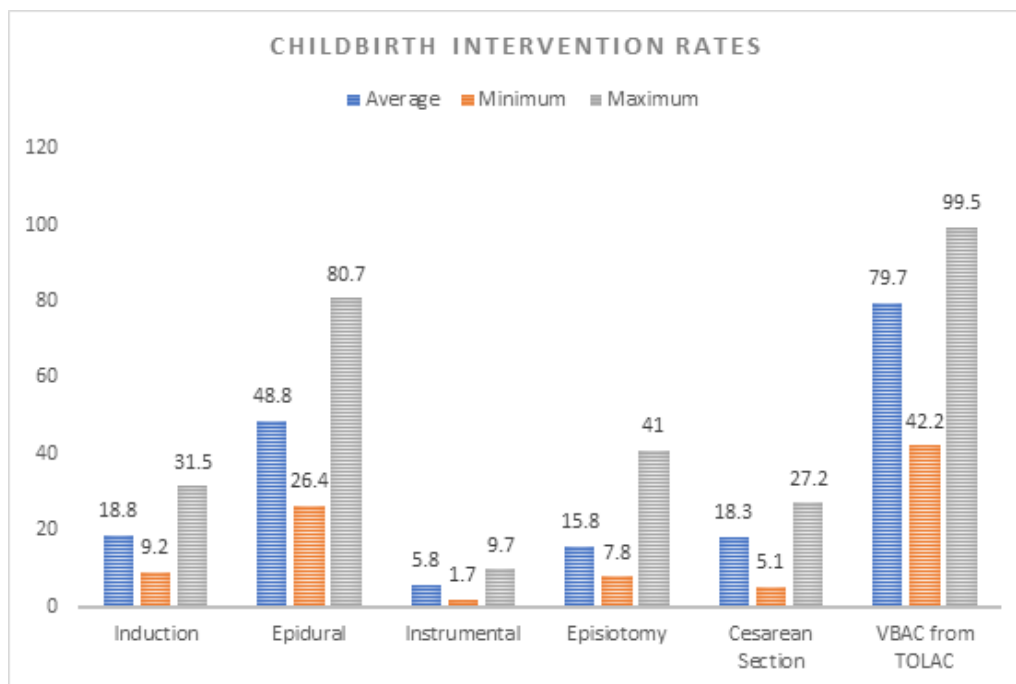


Figure 1: Childbirth intervention rates in Israeli hospitals as per the Israeli Society of Maternal and Fetal Health 2017 Annual Presentations

¹² Ministry of Health, (2012 May 24). Home Births.

¹³ Israeli Society of Maternal-Fetal Medicine (2017). Obstetrics in Israel: Annual Report of 2017. Israel

As depicted in Figure 1, the gaps between the different rates are considerably wide, a fact which raises questions regarding the reasons for these gaps. Since 2016, we have been advocating for transparency of the data, including additional data needed to provide context. For example, a low rate of epidural use can be the result of varying maternal preferences or, alternatively, a shortage of anesthesiologists on call. This has been the first year we have managed to receive the data from public hospitals. However, we have yet to receive an explanation for the context of this partial data.

Furthermore, hospital birth management guidelines vary from place to place, and are not made readily available to the public. Variations may include the pregnancy week in which induction is proposed, the time of antibiotic administration after membrane rupture, or mode of delivery for breech newborns, to name a few. These internal guidelines may have significant consequences for the birth outcomes. This is also true for guidelines relating to interventions which are considered minor, due to the phenomenon known as the "cascade of interventions". If we take the example of breech birth, the obstetrician providing care during pregnancy will most often present caesarean section as the only option, while about 5-6 hospitals do support vaginal deliveries. The same can be said about a pregnancy with two previous caesarean sections. Despite their significance, women are not informed of these guidelines prior to labor.

This lack of transparency means that women do not have access to basic information regarding common approaches and practices in each hospital. In many instances, women in labor are not provided with an alternative to a physician's recommendation, nor informed of guidelines accepted in other hospitals, nor supported in their birth choices if they are not in accordance with the establishment's policy.

5.2 WCB Hotline for the Birthing Woman

One of our main projects has been operating a hotline to provide support and resources for women who have suffered a violation of their rights by a health care provider. We provide a place where women can talk freely about their birth experience and receive emotional support, paralegal and legal consultation, referral to resources and mental health professionals, and assistance in writing a letter of complaint. We also accompany women to meetings with hospital staff members as per their request. The calls we receive are documented, and we are planning to publish a report within the coming year.

Though this data cannot indicate the prevalence of the phenomenon, it reveals a disturbingly high number of violations of women's rights during childbirth. It also allows for an in-depth understanding of how such situations unfold, and of the types and severity of violations reported. Furthermore, as in many types of violence, there is often significant underreporting. This tendency can be expected to be exacerbated when this type of violence is not yet recognized by society at large, as will be further discussed in sections 6 and 12.

In the two years of its operation, the hotline has received approximately 670 reports of mistreatment and violence against women during childbirth. Of these reports, 70% refer to

births occurring between 2013 and 2019. We have categorized the incidences based on the typology suggested by Khosla et al. (Table 1)¹⁴. This typology is comprised of 7 different categories of mistreatments: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health systems' conditions and constraints. Each category is comprised of three orders of details. In view of the testimonies received, we have added categories in the third order, such as unwanted separation with the newborn, Kristeller maneuver, etc.

It should be noted that these categorizations are not mutually exclusive. However, we have tried to classify incidences of mistreatment as one type only. For example, when informed consent was not properly given or requested for a procedure which is considered common practice, we have categorized it as 'failure to meet professional standards of care' although it may also be considered as physical abuse. If the practice referred to is no longer recommended by professional associations, such as the Kristeller maneuver, it was categorized as 'physical abuse'. For the initial data analysis, we have included sexual abuse in the physical abuse category. In addition, the classification included the medical institution, the department in which the incidence has occurred, and the type of intervention related to the mistreatment or violence in question.

The following is a description of our initial data analysis, which is still in process and is yet to be published. As shown below in Figure 2, the reports mainly relate to incidences in the delivery room (60%), in maternity triage (15%) and in the maternity ward after the birth (10%). These results suggest that the experience of delivery itself is more prone to become traumatic, likely due to the intensity of the event, and as a result, the vulnerability of the woman in labor in relation to the medical care providers.

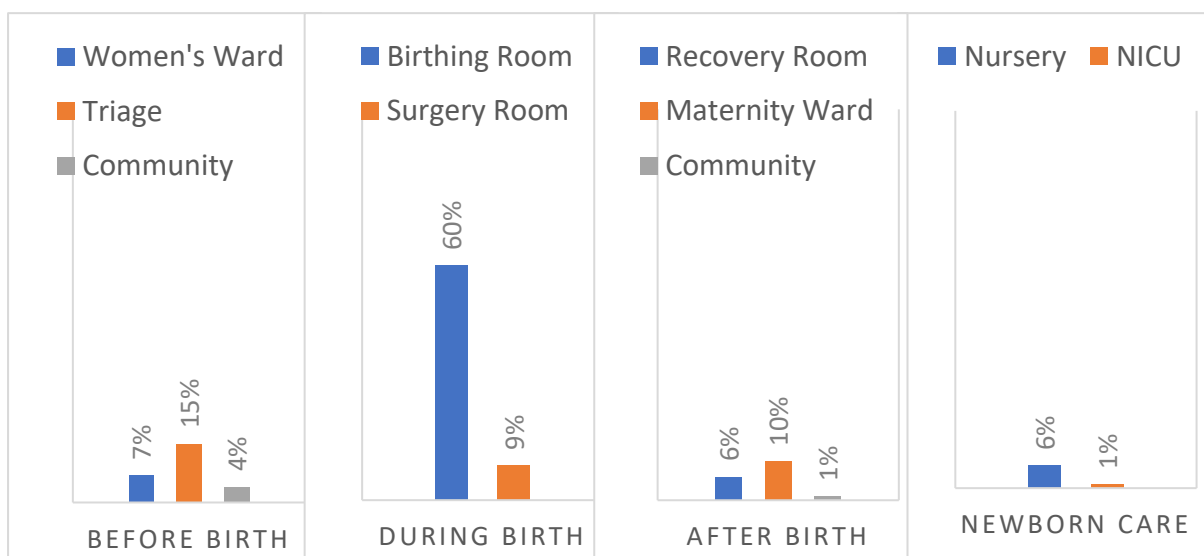


Figure 2: Place of mistreatment occurrence reported by hotline callers

The reports we have received include a wide range of human rights violations, from neglect to physical assault. As our initial findings show, the types of mistreatment and

¹⁴ Khosla, R., Zampas, C., Vogel, J. P., Bohren, M. A., Roseman, M., & Erdman, J. N. (2016). International human rights and the mistreatment of women during childbirth. *Health and human rights, 18*(2), 131.

Third order	Second order	First order	Relevant human rights		
Physical abuse	Use of force	Beaten, slapped, kicked, and pinched during delivery	<ul style="list-style-type: none"> • Right to be free from violence • Right to be free from torture and other ill-treatment 		
	Physical restraint	Physically restrained to the bed or gagged during delivery			
Sexual abuse	Sexual abuse	Sexual abuse or rape	<ul style="list-style-type: none"> • Right to non-discrimination • Right to health 		
Verbal abuse	Harsh language	Harsh or rude language	<ul style="list-style-type: none"> • Right to privacy (including physical and mental integrity) • Right to be free from practices that harm women and girls • Right to information • Right to decide the number, spacing, and timing of children 		
		Judgmental and accusatory comments			
	Threats and blaming	Threats of withholding treatment or poor outcomes			
		Blaming for poor outcomes			
Stigma and discrimination	Discrimination based on socio-demographic characteristics	Discrimination based on sex and/or gender	<ul style="list-style-type: none"> • Right to non-discrimination • Right to be free from torture and other ill-treatment • Right to health • Right to decide the number, spacing, and timing of children • Right to information 		
		Discrimination based on ethnicity/race/religion			
		Discrimination based on age			
	Discrimination based on socio-economic status				
	Discrimination based on medical conditions	Discrimination based on HIV status			
Failure to meet professional standards of care	Lack of informed consent and confidentiality	Lack of informed consent process	<ul style="list-style-type: none"> • Right to privacy • Right to health • Right to non-discrimination • Right to be free from violence • Right to information • Right to decide the number, spacing, and timing of children • Right to be free from torture and other-ill treatment 		
		Breaches of confidentiality			
	Physical examinations and procedures	Painful vaginal exams			
		Refusal to provide pain relief			
		Performance of unconsented surgical operations			
	Neglect and abandonment	Neglect, abandonment, and long delays			
Skilled attendant absent at time of delivery					
Poor rapport between women and providers	Ineffective communication	Poor communication	<ul style="list-style-type: none"> • Right to privacy • Right to information • Right to non-discrimination • Right to be from torture and other ill-treatment 		
		Dismissal of women's concerns			
		Language and interpretation issues			
		Poor staff attitudes			
	Lack of supportive care	Lack of supportive care from health workers			
		Denial or lack of birth companions			
	Loss of autonomy	Women treated as passive participants during childbirth			
		Denial of food, fluids, and mobility			
		Lack of respect for women's preferred birth positions			
		Denial of safe traditional practices			
		Objectification of women			
				Detainment in facilities	
	Health systems conditions and constraints	Lack of resources		Physical condition of facilities	<ul style="list-style-type: none"> • Right to privacy • Right to health • Right to information • Right to non-discrimination • Right to and effective remedy
Staffing constraints					
Staffing shortages					
Supply constraints					
Lack of privacy					
Lack of policies		Lack of redress			
Facility culture		Bribery and extortion			
		Unclear fee structures			
		Unreasonable requests of women by health workers			

Table 1: Typology of mistreatment of women during facility-based childbirth and relevant human rights (taken from Kohsla et al., 2016)

violence women have endured as related to childbirth, in order of prevalence, were: poor rapport between women and providers (99%), failure to meet professional standards of care, including unconsented procedures (96%), verbal abuse (66%), physical abuse (29%), health systems' conditions and constraints (22%) and stigma and discrimination (16%) (see Figure 3).

On average, women reported having undergone three different types of mistreatment during the same birth event.

Reports of verbal abuse include threats to stop care; threats of giving treatment without consent; blunt admonitions including warnings of catastrophic outcomes if consent was not given; harsh or rude comments; derogatory comments such as inappropriate comments on physical appearance; discrimination on the basis of weight or religion; blaming for poor outcomes; a disregard for women’s pain, and dismissive comments about women’s ability to birth without anaesthesia.

Reports of women regarding poor rapport between them and providers included behaviors such as ignoring the woman’s questions during her treatment; speaking in a language the woman is not meant to understand; speaking ‘over’ the woman and not to her, using unexplained medical terms; lack of support of the woman’s birth choices; refusal of the woman’s requests without explanation; presenting treatment as mandatory instructions instead of as recommendations; gossiping about other birthing women next to the woman; and arguing with the woman about her own bodily sensations. We are still in the process of analyzing the data so that we gain a better understanding regarding the third order of the different categories of women’s rights violations.

The types of interventions mentioned in women’s accounts relating to non-consented care were: epidural anaesthesia (21%), vaginal examination (19%), episiotomy (18%), suturing (18%), induction and birth augmentation (14%), external monitoring (13%), emergency caesarean (13%), vacuum-assisted labor (10%), stripping of the membranes (8%), IV perfusion (8%), rupture of membranes (8%), vaccination and care given to the newborn (6%), medical examination of the newborn (4%), ultrasound (3%), newborn feeding (3%), uterus revision (3%), Kristeller maneuver (3%), internal monitoring (2%), nitrous oxide administration (2%), Pitocin perfusion for uterus contraction after birth (2%), elective caesarean (1%), pregnancy check (1%), and standard physical examination (1%). Further analysis which may provide more explanations, will be included in the final report.

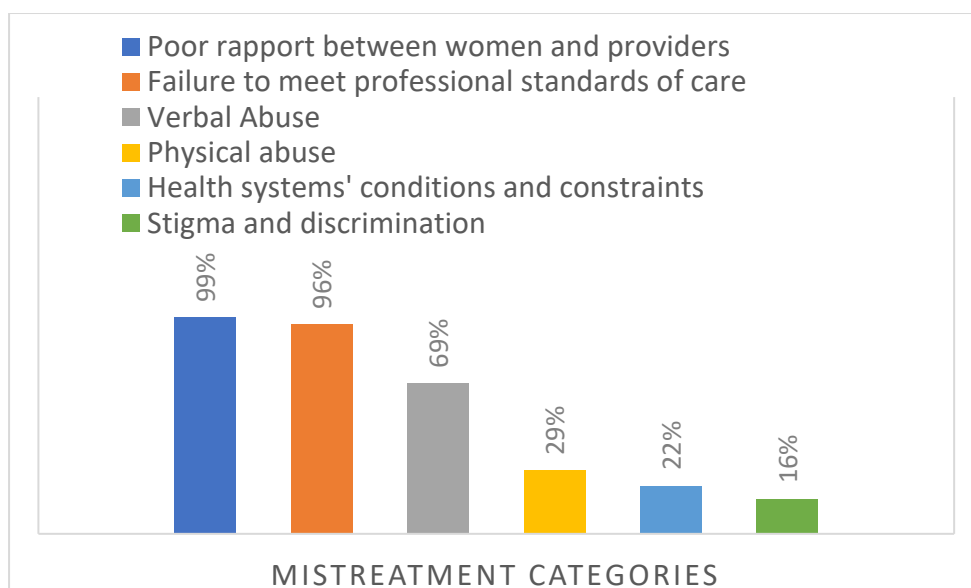


Figure 3: Mistreatment and Violence Classification

We would have expected that most interventions related to non-consented care would be emergency or lifesaving interventions, such as emergency cesarean sections, vacuum-assisted labor, or NICU care. Interestingly, the main interventions mentioned, as epidural anesthesia, vaginal examinations, and suturing, are those which are not needed in immediate lifesaving situations. This is a testament to the fact that these violations are clearly preventable and are highly dependent on policies, practices and care approaches that are currently considered as common or standard.

Examples of violations that were categorized as physical assault include forcing into a supine position, tying hands during a cesarean section with no previous explanation, aggressive transfer from bed to bed, manual ripping of the perineum, and performing of the Kristeller maneuver.

In addition, it is important to note that barring a few technical questions, the hotline callers are not prompted to answer specific questions. The purpose of the hotline is to provide support and allow women to share what they wish relating to their birth experiences. Therefore, we do not have statistical data regarding the effects of the reported violations, both immediate or long term, such as women's mental health in the postpartum period; their bonding with their baby; their relationship with their significant other; their ability to rebuild their trust in the medical establishment; or their experience with future pregnancies and births.

However, some women choose to share some of this information of their own accord. In an initial qualitative analysis, one theme that emerged from women's accounts was a sense of objectification, or dehumanization. One caller described the physician who operated on her as a "butcher", saying he cut her open, but ignored her completely, refusing to answer any of her questions. Another caller described the anesthesiologist as treating her as if she was a "piece of wood". Other women used terms such as feeling like "air", "a slab of meat", "merely a lower part of the body", or "an exhibit on display". Still others felt decentered from their own birth, as one caller described her birth as "a play in which my participation was marginal". In some cases, women used the term "rape" to describe their experience of the events of their birth.

Regarding their immediate reactions, some callers described feeling humiliated, shocked and afraid. Others described themselves freezing, shaking, crying uncontrollably, or remaining speechless in response to the violations they have experienced. Some wanted to stop feeling what is happening, or to disengage. As one woman said, "I wanted to go to sleep and not wake up."

When referring to longer term emotional responses, some women described feeling depressed or suffering from post-traumatic stress disorder. Others described specific avoidance, numbing, or arousal symptoms. For instance, women mentioned crying or tearing up when recalling the events of the birth, ruminating about the events before sleeping, feeling anger when thinking about it, having difficulty thinking about the birth at all, or feeling emotionless and as if they were "shut down".

Further analysis will be included in our final report to provide explanation for the figures presented above and to describe additional themes emerging from women's reports.

5.3 Survey of the Experiences of Women during Gynecological Examinations

In 2017, Keren Briah, an advocacy group working to improve women's health in Israel, published a report based on an online survey of women regarding their experience of gynecological examinations. The survey was answered by 6,508 women. We have summarized here some of their findings.

Nearly half of the women surveyed (47.1%) rated the examination as embarrassing or very embarrassing. When asked to rate the level of pain experienced, about a third of the women (35%) rated the examination as moderately painful to severely painful. When asked to rate the level of trauma they have experienced due to the examination, if at all, nearly a fifth (18.6%) of the women surveyed rated the examination as traumatic or very traumatic¹⁵. Overall, 42.9% of the women reported that they were satisfied or very satisfied with the HMO gynecologists, while 22.8% reported that they were dissatisfied or highly dissatisfied¹⁶.

The findings show that not being warned before potentially painful procedures was a significant predictor of the level of trauma reported by the participants¹⁷. When asked to rate how often they were warned before painful procedures during previous examinations (on a scale of 1-*never*, to 5-*always*), the average score reported by women was 3.02¹⁸. Furthermore, many women reported that their care providers responded dismissively to their expression of pain.

The experiences of women during gynecological examinations were also assessed using open-ended questions. Many women described the sense of vulnerability inherent in this situation. As one participant put it, "the most important thing is to understand that this is a very vulnerable and exposed situation, more than almost any other medical examination, and it is important that doctors be sensitive to this". Another participant said, "there is a lack of awareness and understanding of the sensitivity [required], the vulnerability of these examinations, and the helplessness involved."¹⁹

Of the women surveyed, 16% declared that they have encountered an inappropriate question or comment at least once during a gynecological examination. Within those cases, 43% were related to the appearance and weight of the woman, 37% were related to the sexual life, sexuality and gender of the woman, 15% were related to the woman's choices as related to childbirth and reproduction, and 5% were related to the woman's choices regarding contraception.

In general, it was found that most women do not refrain from getting a gynecological examination (76% indicated that they had consulted a gynecologist in the past year). However, the findings show a high turnover rate of physicians among the women surveyed.

About half of the women reported that they have changed over 5 gynecologists throughout their lives. More than a third of the participants (37%) changed between 5 to 7 gynecologists, and 9% changed their gynecologists more than 8 times. Another 40% of the

¹⁵ Keren Briah. (2017). *The Gynecological Examination Report*. Israel, p. 6

¹⁶ Ibid., p. 19

¹⁷ Ibid., p. 17

¹⁸ Ibid., p. 16

¹⁹ Ibid., p. 19

women reported changing between 3 to 4 gynecologists during their lives. The most common reason for switching between gynecologists was "I was not comfortable with the previous gynecologist" (53%). Beyond the technical reasons for the substitution (relocation or absence of appointments), the following common reason was the desire to switch to a woman gynecologist (31%)²⁰. As a result, women do not get needed care, a fact which may have future consequences for their health.

Of the women who had not been to a gynecological examination for more than a year, reasons for avoiding screening were examined. The most common reasons for avoiding a test was the absence of a medical need (62%), a sense of unease with the examination itself (36%), or not finding a doctor with whom the woman feels comfortable (30%).

Additional data is provided in Keren Bria's report, which also elaborates specifically about women who have had a previous experience of sexual abuse.

5.4 Initial Data from our 'What Women Want' Survey

During the second half of 2018, we conducted a survey in collaboration with Keren Bria, asking women to share the kind of care they want during pregnancy and childbirth. A total of 3,467 women responded to the survey. Of these respondents, 3,204 fulfilled the study criteria, which were giving birth at a hospital within the past 5 years or being pregnant and planning to give birth at a hospital. While the survey is comprised of seven different sections, we will focus here mainly on data related to previous experiences of women, rather than preferences for future births. The results have not been published yet, however we have initial statistical analysis relevant to this report.

The survey consisted mainly of closed ended questions, in which respondents were asked to rate various aspects of the care they received on a scale from 1 (*not at all*) to 5 (*to a large extent*). When women were asked to rate their emotional state after the birth as compared to before the birth, 37% felt worse or much worse, 33% felt better or much better and 29% felt the same. When asked about aspects of the care they have received, 67% of the women surveyed reported the medical team presented themselves 'to a great extent' or 'to a very great extent', whereas a full third of the women surveyed (33%) reported that the medical team presented themselves 'to a moderate extent', 'to a little extent' or 'not at all'. Most of the women (78%) rated the level of respect they were shown by the team as 'to a great extent' or 'to a very great extent'. However, nearly 1 in 4 women (22%) rated the respect they were shown by care providers as 'to a moderate extent', 'to a little extent' or 'not at all'.

Informed consent before medical interventions or examinations was reported to be obtained 'to a great extent' or 'to a very great extent' by 70% of the women surveyed. However, 30% of the women reported that informed consent was obtained from them 'to a moderate extent', 'to a little extent' or 'not at all'. When asked about their involvement in the birth process, 66% of the women felt they were involved 'to a great extent' or 'to a very great extent', while 34% felt they were involved 'to a moderate extent', 'to a little extent' or 'not at all'. When asked to what extent they were provided with information and explanations about

²⁰ Ibid., p. 20-21

procedures before they were performed, 66% reported that the medical team provided such information 'to a great extent' or 'to a very great extent', while 34% of the women reported that information was provided to them 'to a moderate extent', 'to a little extent' or 'not at all'. Regarding the respect their choices were given, 67% of the women felt their choices were respected by the team 'to a great extent' or 'very great extent', whereas 33% of the women reported that their choices were respected 'to a moderate extent', 'to a little extent' or 'not at all'. When asked to rate how amicable the staff members were, 74% of the women answered 'to a great extent' or 'to a very great extent', whereas 26% of the women answered 'to a moderate extent', 'to a little extent' to 'not at all'.

Of those who reported being told disrespectful statements, most of the women said these statements were related to their behavior and/or their functioning during the birth (see Figure 4 below).

Women were also provided with the opportunity to write freely about the subject. From an initial qualitative analysis, we see that the different statements heard by women were often related to epidural anesthesia, similar to the findings we observed in our hotline data. These statements were commonly related to a lack of confidence in the ability of the woman to birth naturally, disregard for the woman's threshold of pain, and disregard for her desire for pain relief.

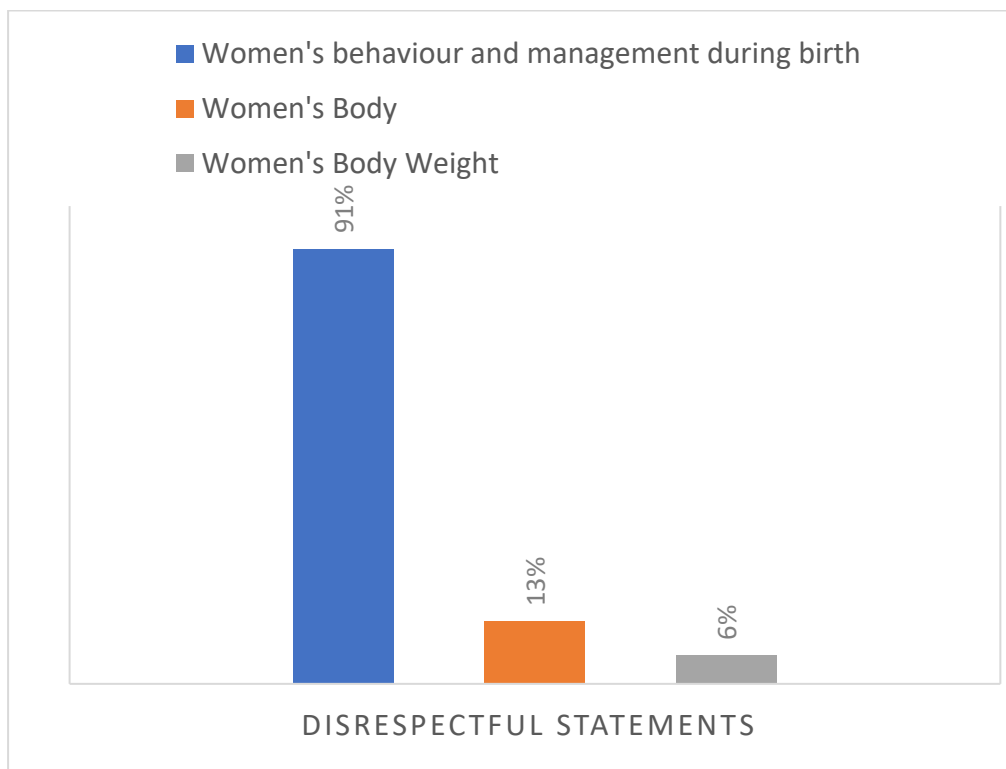


Figure 4: Types of Disrespectful Statements Heard by Women During Childbirth

5.5 Academic Research

Generally speaking, there is a dearth of quantitative and qualitative data on the phenomenon in Israel. Most related studies focus on postpartum mental health issues, such as post-traumatic stress disorder and postpartum depression. We strongly urge more research on this subject, since studies show a strong correlation between postpartum mental health issues and the woman's experience of her birth²¹. Below we will describe the results of some of the researches recently carried out in Israel.

In 2014, a study was performed in a hospital located in the center of Israel, aiming to investigate postpartum anxiety in the general population as well as possible related factors²². Of the 89 women included in the study, a remarkable rate of 40.4% showed high anxiety scores. When correlating factors were examined, a significant association was found between postpartum anxiety and depression in the last weeks of pregnancy, postnatal depression, as well as post-traumatic stress disorder. There was no association found between postpartum anxiety and objective risk factors such as birth complications. There were, however, associations found between postpartum anxiety and subjective experiences of birth, such as the woman's fear of birth, a sense of danger at birth to herself or to the fetus, a feeling of lack of control during labor, and reduced confidence in herself and the medical staff. Of the women who developed postpartum anxiety, 75% reported feelings of anger, fear, or emotional detachment during labor. There was little discussion in the article of potential reasons for these strong emotions. The focus was purely on the subjective experiences of the women.

Another study was presented in a news article, for which, unfortunately, we have not managed to find the original article. The study was carried out by Liran and Hamdan. In 2016, they distributed screening questionnaires for postpartum depression among 1,023 women who were pregnant or up to a year after birth. The participants were recruited from all over the country and from all ethnic origins in Israeli society. According to the news article, the incidence of postpartum depression was found to be 25%, twice the rate in the Western world, where the rate of depression is about 12%. The rate of postpartum depression found in Israel was even higher than in low income countries, with 9% of the subjects showing suicidal tendencies²³.

In 2018, the Knesset Information and Research Center published a report related to available data regarding postpartum depression. Citing estimations of the MoH, the report states that approximately 10%-15% of women experience postpartum depression. In Israel, according to the National Insurance Institute data, there were 180,000 births in 2016. Thus, in that same year, it is estimated that between 18,000 to 27,000 postpartum women suffered from postpartum depression.

²¹ Hollander, M. H., Van Hastenberg, E., Van Dillen, J., Van Pampus, M. G., De Miranda, E., & Stramrood, C. A. I. (2017). Preventing traumatic childbirth experiences: 2192 women's perceptions and views. *Archives of women's mental health, 20*(4), 515-523.

²² Polachek, I. S., Harari, L. H., Baum, M., & Strous, R. D. (2014). Postpartum anxiety in a cohort of women from the general population: risk factors and association with depression during last week of pregnancy, postpartum depression and postpartum PTSD. *The Israel journal of psychiatry and related sciences, 51*(2), 128-134

²³ Gal, I. (2016 April 4). Research [shows]: Highest Postpartum Depression Rate in Israel. *ynet*

5.6 Zero Separation Data

The following information is based on reports that have reached Zero Separation (NPO), an Israeli organization working to maintain the rights of parents and newborns to remain together throughout their hospital stay post-birth. It is important to note that there have been significant yet slow changes in this field of care. However, these changes have been adopted by individual hospitals, not as a nationwide policy, and are often inconsistently implemented. Furthermore, these changes were brought about in large part due to persistent social media campaigns and advocacy.

Broadly speaking, practical care for mothers and newborn babies in Israel does not meet the international recommendations for adequate care in the post-birth period, as specified in several publications and guidelines issued by leading associations in the field²⁴.

If the mother arrives prepared beforehand with knowledge on the subject, and knows precisely what to ask for, in most cases she will be cared for according to her requests. Unfortunately, most mothers are not aware of their rights and hospitals do little to inform them. In addition, in most hospitals there are certain circumstances in which the mother's rights as the legal guardian of her baby will not be maintained, even when she is fully aware of her rights and explicitly asks that they be respected. The following are common cases of improper care of mother and newborn baby post-birth.

Immediately after birth, most babies in Israel do not receive skin-to-skin touch for more than a few minutes, since many midwives are not informed of the benefits of skin-to-skin. After fifteen minutes or so the baby is taken to be weighed, is wrapped in a nappy and blanket and laid down in a crib. At other times, the baby is handed to the father until after the delivery of the placenta and the suturing of the mother's lacerations, after which the newborn is handed back to his or her mother still wrapped in blankets.

About 60-90 minutes after birth, the baby is separated from his or her mother and wheeled away to the nursery. The mother is not asked whether she wants this separation, nor does she receive any information about the implications of this separation on her and on her newborn. This is despite evidence to suggest this separation has an adverse impact on the mother and baby dyad²⁵. On the contrary, the mother receives an explanation that this is the standard procedure and that she will receive her baby once the process of checking him or her into the hospital is over.

At this point, the baby undergoes a number of examinations and treatments at the nursery, including a hepatitis shot, a vitamin K shot, a rectal temperature check, weighing, a shower (not a bath), eye cream, and a blood test for jaundice/sugar level (in some cases). These examinations are often done without a due process of informed consent, and

²⁴ Feldman-Winter, L., Goldsmith, J. P., & Task force on sudden infant death syndrome. (2016). Safe sleep and skin-to-skin care in the neonatal period for healthy term newborns. *Pediatrics*, 138(3).; National Collaborating Centre for Women's and Children's Health UK. (2014). Intrapartum care: care of healthy women and their babies during childbirth.; World Health Organization. (1998). *Evidence for the ten steps to successful breastfeeding* (No. WHO/CHD/98.9). Geneva: World Health Organization.

²⁵ Morgan, B. E., Horn, A. R., & Bergman, N. J. (2011). Should neonates sleep alone?. *Biological psychiatry*, 70(9), 817-825.

sometimes without any notification of the parents. Furthermore, these treatments are mostly done without an escort, unless the father or significant other explicitly asks for this, and are sometimes done without any pain relief for the newborn.

It should be noted that the standard ratio of nurses to babies is approximately one nurse to 10-15 newborns. This undoubtedly has significant implications for the care provided to newborn babies. Newborns often spend several hours in the nursery, where they are undressed and put in a heated bed. There they wait under a heating lamp for their turn to receive care. Their parents are often instructed to leave them there to wait for care alone. In some hospitals, parents who request that the treatments be carried out in their own room by their side, or otherwise to be present while their baby receives these treatments, are met with resistance and antagonism by the staff and are asked to leave the nursery.

During the hospital stay, there is a requirement, sometimes communicated by a speaker announcement, to return all babies to the nursery. While they are there they receive treatments once more, again with no parental supervision, without parental agreement or knowledge and often with no pain relief. Furthermore, newborns are often given formula in the nursery, without the parents' knowledge and sometimes despite their explicit refusal.

Many hospitals employ a mandatory policy of separation between the mother and baby for babies with risk of hypoglycemia, in order to supervise the baby's sugar levels, especially in the first few hours. Sometimes this separation occurs before the first breastfeeding. Furthermore, in most hospitals, if the sugar level is under 40/45 mg/dl, the newborn is moved to the nursery without his or her mother, receives formula in order to balance the sugar levels and remains separated until sugar levels reach 50-60. This is against international protocol²⁶.

Other situations also lead to hours of separation, whenever the babies fall under the criteria of the hospital's risk protocol, as in cases of SGA, twins, vacuum extraction, toxemia, and C-section, among others. These babies are automatically separated from their mother for many hours, even if they are stable and healthy.

Most hospitals in Israel do not have a gentle C-section plan, but rather separate baby from mother for hours directly after the birth. The few hospitals that do implement this program, activate it only upon the mother's request in advance.

When a mother is having difficulty with her baby, most often she will not receive help but rather be told to leave the baby with the nurses in the nursery and rest without the baby.

The attitude of the nurses, staff and physicians in Israel to the parents is often dismissive and ignores their right to know what is happening with their baby, including their right to refuse treatments. Parents often report getting the impression that they are irrelevant and not responsible for their own baby, and that the hospital has the right to choose for them. This negatively affects their confidence in their ability to take care of their baby on their own.

To the best of our knowledge, the MoH has not undertaken any significant steps to examine possible mistreatment or inadequate care in hospital nurseries in Israel. Though the MoH has officially adopted the recommendations of the WHO Baby Friendly Hospital Initiative (BFHI), published in 1992, these recommendations have yet to be implemented.

²⁶ Adamkin, D. H. and Committee on Fetus and Newborn, (2011). Clinical Report—Postnatal Glucose Homeostasis in late-preterm and term infants. *Pediatrics*, *Pediatrics*, 127(3), 575-581.

6. Public Discourse

6.1 Obstetric Violence in Israeli News Media

In recent years there have been several newspaper articles relating to obstetric violence. Some of them have even appeared in mainstream media outlets, with direct, bold headlines, such as “‘Lady, you’re not in pain - stop screaming’: Women reveal the demeaning treatment of physicians in Israel”²⁷, or ‘Insensitivity, humiliating treatment, medical risks. Has the medical system been systematically violating the rights of the birthing woman?’²⁸. However, these articles, being few and far between, have not led to significant media follow up, public outrage, or more robust accountability measures being taken by the medical system. Official responses to these news publications will be discussed in section 9.

Occasionally, newspaper articles have covered the topic of maternal mental health, but these have emphasized the subjective experience of women during birth, with no mention of obstetric violence. In the same vein, several television shows featured interviews with psychiatrists specializing in maternal mental health issues. Though they were asked to speak about some women’s fear of birth, they have not discussed any objective violations that may be the cause of those fears²⁹.

Other news articles have conveyed the message that Israel is faring better in its maternal care services compared to other countries. One such article discussed the study by Bohren et al., which reviewed the ‘mistreatment and abuse of women during childbirth in health facilities globally’³⁰. It also featured an interview with the head of the Society for Patient Rights in Israel. While he did mention the slim chances of women of disadvantaged populations reporting the violation of their rights, he also argued that maternal care services in Israel are better than those depicted in the study, mainly due to economic incentives of the hospitals to attract patients. As was presented in the news article, his view was not based on any active inquiry, but rather on his impression from the few complaints that have reached the organization.

6.2 Obstetric Violence on Social Media

In recent years, women have been increasingly sharing intimate accounts of their births on topic related Facebook pages, such as 'Active Birth, Natural Birth and Home Birth'. At times, women have also shared accounts of rights violations, mistreatment or outright

²⁷ Klingbale, S. (2018 June 10). ‘Lady, you’re not in pain - stop screaming’: Women reveal the demeaning treatment of physicians in Israel. *The Marker*

²⁸ Limone, N. (2015 June 11). Insensitivity, humiliating treatment, medical risks. Has the medical system been systematically violating the rights of the birthing woman? *Haaretz*

²⁹ Eisenberg Romano, G. (n.d.). Interview by R. Karaso. Healthy Living [Television Broadcast]. Israel: Channel 10. Retrieved from <https://www.youtube.com/watch?v=jrDOKXZtcs>; Huller Harari, L. (n.d.) Interview by R. Karaso. Health 10 [Television Broadcast]. Israel: Channel 10. Retrieved from <https://www.youtube.com/watch?v=ssv4KDljs9c>

³⁰ Shimoni, M. (2015 July 14) Study: Many women experience abuse during birth, *Walla! News*

obstetric and reproductive violence. However, these stories have most often been shared in closed groups, many of which are not considered mainstream, mainly in order to consult with each other, receive or give support to other women, or to cautiously warn others of potentially harmful health providers. Most of these stories have not been part of any concerted campaign to raise awareness to such violations. Therefore, they have not attracted much media attention. An exception to this was a news article published in a central Israeli newspaper, 'Israel Today', which was based on a thread to a post published on the Facebook page of Keren Bria, an advocacy group mentioned earlier. The article was titled 'Cesarean section, I have my hands tied. Two physicians are handling my body and talking about soccer'³¹.

6.3 Public Awareness

Despite these several news articles mentioning obstetric mistreatment and violence in the media, there seems to be little public awareness of the phenomenon. The term 'obstetric violence' is rarely used and is virtually unknown, neither among the general public nor among professional circles.

To illustrate this, the parliament committee dedicated to improving women's status in society has recently held a discussion about prevention and treatment of postpartum depression. Among the causes mentioned by the participants of the discussion were socioeconomic factors, the mother's isolation in the postpartum period, the wide gap between parents' expectation of this time and reality, and domestic violence. There was no mention of human rights violations during childbirth or even of women's subjective experience of the birth as possible causes³².

An example of the normalization of these violations can be seen in the popular reality TV show called 'Baby Boom', which depicts women giving birth at several hospitals in Israel. Several episodes show disrespectful dialogues between staff members and the woman in labor, in which the woman attempts to refuse examinations, while the care providers respond dismissively to her wishes, or agree to merely postpone the examination, phrasing their recommendations as mandatory instructions. This is all done in front of the cameras. These interactions are normalized and legitimized in the public discourse as necessary medical treatment, ignoring the clear violation of human rights involved in the lack of respect given to the woman's refusal of treatment³³.

At this point, we would like to add that we are extremely grateful for the advocacy work of individual researchers and practitioners who help raise awareness of the violation of women's rights during reproductive health care. We are also aware of several studies currently underway that may shed more light on the effects of events during birth, and specifically of mistreatment and abuse of women, on postpartum mental health. However,

³¹ Amaroussi, E. (2018, May 10). Cesarean Section, I Have My Hands Tied. Two Physicians Are Handling My Body and Talking about Soccer, *Israel Hayom* [Israel Today], weekend magazine.

³² Knesset Committee on the Status of Women and Gender Equality. (2017). February 7 Discussion (Protocol No. 146).

³³ Gil, Assaf. (Producer). (2013). *Baby Boom* [Television Series]. Tel Aviv, Israel: Gil Productions Ltd.

these have not been published yet. Therefore, we cannot include them in our analysis of the public discourse in its current status.

7. Institutional Mechanisms for Maintaining Patient Rights

7.1 Birth Pregnancy Care

As part of the care provided within the different HMOs, some offer additional support for first time pregnant women by nurses, beyond the standard prenatal care. This support consists of one on one meetings where women are provided with explanations and instructions as related to the different pregnancy check-ups and tests. These meetings are an opportunity for women to discuss their concerns or raise any questions they have. In practice, however, only few women are aware of this possibility. As this nurse will not be present at birth, the birth itself and all that is related to it is often not discussed during those meetings.

7.2 Birth Preparation Courses

Birth preparation courses are generally provided by hospitals or HMOs. These courses are standardized, and mostly include key terms regarding the process of birth, such as dilation or spines, or basic instructions for the woman, such as when to arrive at the hospital. There is no special emphasis on women's rights during birth, nor in depth explanations of common interventions, pain coping methods or birth alternatives. Furthermore, only recently has breastfeeding preparation been included within these courses.

Women can, if they wish, subscribe to private birth preparation courses provided by doulas or hypnobirthing instructors, which provide alternative standpoints to the conventional preparation. However, the extent to which they refer to women's rights during labor and delivery varies widely.

7.3 Consent Forms

Hospitals do attempt to ensure informed consent, by asking women to sign consent forms. This section refers to the consent forms as they were presented in a guideline published by the MoH. It does not take into account adjustments that may have been made by individual hospitals, nor the possible interactions between the birthing woman and the medical team.

When a woman arrives at a hospital, she is asked to sign an informed consent form in order to receive medical care during birth. The form states that the woman is aware that during the birth, different interventions may be required. A short list of procedures is provided, including infusion preparation as it is routinely made, use of internal or external monitoring, blood sampling from the newborn head, episiotomy as needed, instrumental birth as needed and birth augmentation. Moreover, the woman attests that she is aware that

those interventions may bear a degree of risk for potential complications, and that if a complication arises, additional and other interventions may be required for life saving purposes and for preventing any physical damages. She is also asked to sign an additional informed consent form listing the list of tests the newborn will undergo³⁴.

These two forms represent a breach of the autonomy of the woman and newborn. Although they are called 'informed consent' forms, it could be argued that they are in fact informed consent waivers, establishing the control in the hands of the medical team. The newborn related form does not provide the option for the parents to choose which tests they want their infant to undergo. The woman's birth related form does not take into account the woman's will while birthing and her real-time consent for an intervention. Instead, she is asked to decide in advance whether she agrees to such interventions. Thus, birth is presented to the woman as a highly risky and medicalized event. She is instructed to sign these consent forms as a condition of care. This approach recognizes the right to survive as the aim of birth, whereas the violation of other human rights of women becomes invisible.

Furthermore, the form places simple interventions as infusions or blood tests at the same level as more invasive and significant interventions, as an episiotomy and an instrumental birth. These last two types of interventions may have heavy consequences on the woman's experience of birth and on her future intimate life. Despite this, she is not asked to review and discuss this information during prenatal care, and so she is often not made aware of the implications of each intervention. For some women, this may be the first time they hear about these interventions or treatments.

Other consent forms, for procedures such as epidural analgesia and a cesarean section, are usually presented to the birthing woman while in labor, sometimes even during contractions, which makes it difficult to comprehend the information written on the form or to ask relevant questions. As the woman in labor does not know her caregivers in hospital before the birth, she has no opportunity to discuss those matters with them beforehand.

Thus, consent forms are often used as a substitute for the actual process of informed consent, which as ACOG's ethical committee states, 'includes a mutual sharing of information over time between the clinician and the patient to facilitate the patient's autonomy in the process of making ongoing choices.'³⁵This practice is also in contradiction with statements of the MoH on the matter³⁶. The existence of this practice is confirmed in a report issued by the state comptroller, which stated that physicians admit they often give patients partial information in a hurried manner, due to lack of time³⁷. As such, consent forms often serve mainly as a legal defense for the medical staff and not as assistance to the patient's decision making process.

In light of this, we recommend that health care providers who treat pregnant women routinely advise their patients to read the consent forms of their chosen hospital before they go into labor and encourage them to ask further questions for later discussion. Implementing

³⁴ Ministry of Health, (2012 Nov. 13). Delivery Room Management Guidelines.

³⁵ American College of Obstetricians and Gynecologists. (2009). Informed consent. ACOG Committee opinion no. 439. *Obstet Gynecol*, 114, 401-8.

³⁶ Ministry of Health, (2006, April 3). Charter of Patient Rights in View of Care Provider Obligations.

³⁷ Israel. Comptroller's Office. (2015). Maintaining the Rights and Dignity of the Hospitalized Patient, Annual Report 65c, p. 504

this practice into the routine of care during pregnancy can help to promote the agency of birthing people in their own health care decisions, and thus establish a true process of informed consent. In addition, we strongly endorse a suggestion, raised by Cristen Pascucci in verbal communication, to add a refusal section to every consent form³⁸. This will allow the birthing woman to fully exercise her autonomy and provide true and free consent when asked to sign such forms.

7.4 Verbal Communication before Examinations

Before performing an examination, a caregiver should provide information to a patient, and proceed only after obtaining informed consent. In practice, caregivers often announce that a certain examination will be performed, without necessarily explaining the aim or necessity of it. This can even be seen on the TV show 'Baby Boom'. This is critical in the case of vaginal examinations as it relates to intimate body parts and patient sexuality. Due to the hierarchy of the caregiver-patient relationship, women often do not question these examinations and remain in a passive position where they are considered not having the needed knowledge to determine whether a vaginal check should be carried out. We believe that measures should be taken to balance this situation. As a starting point, reproductive health care providers should be well aware that examinations can be stopped at any time upon a woman's request. They should also inform or remind their patients of this right before every physical examination.

7.5 Patient Rights Posters

Patients are often informed of their rights via posters presenting The Patient Rights Act-1996, translated to several languages spoken in Israel - Hebrew, Arabic, English and Amharic. To accommodate for these translations, these posters can be found in hospital corridors or in HMOs, written in small print.

Postpartum patients, in addition to tending to their own recovery, have a newborn to take care of. Information presented in this way is less likely to be of real use to women during such a vulnerable time in their lives. Therefore, critical information such as patient rights should not be merely made available to them, but rather effectively communicated at the appropriate time and setting. We recommend informing women about their rights in the context of labor and delivery as early as their prenatal care, and again before any invasive examination or medical intervention, as mentioned above.

³⁸ Pascucci, C., founder of Birth Monopoly, personal communication, May 15 2019.

7.6 Satisfaction Questionnaires

Hospitals attempt to assess women's satisfaction of their care during childbirth using various internal assessment measures. Some distribute questionnaires to women during their hospital stay. Others call a random sample of the women several weeks after the birth, and some send surveys via phone messaging. These surveys include questions regarding the cleanliness and convenience of the facility, the extent to which patients were informed of specific rights, and the attitude and care shown by staff members, among others.

Though these surveys serve an important purpose, they have several limitations. First, they are not suitable for obtaining information about traumatic events. The processing of a traumatic event takes time, and is often characterized by initial denial or shock. This is even more so when the act of violence has been committed in an institutional setting which the woman is highly dependent on and is accustomed to trust. Moreover, women are rarely debriefed after the birth, and so they are often left with unanswered medical questions regarding the events. This further hinders their ability to make sense of their experience.

Furthermore, the very purpose of these surveys as 'satisfaction surveys' (which is often their title) frames the events in consumerism terms, while obscuring the discourse of human rights related to treatment. While this may be suitable for some aspects of the care and the hospital stay, where mistreatment and violence are involved, it is highly misleading. Since there is little to no societal acknowledgement of this type of violence, the processing of the event becomes even more difficult.

Finally, during their hospital stay, and even during delivery itself, women often encounter numerous staff members. Their interactions with different care providers may vary widely. Thus, women may feel extreme emotions towards different staff members, ranging from immense gratitude, love, appreciation, indifference, frustration, anger, to rage, depending on the interactions they've experienced. Hence, it is difficult to answer questions that make generalizations about all staff members.

In light of these limitations, we urge the MoH to allocate resources for conducting an extensive longitudinal study carried out by external researchers, in order to gauge the true prevalence of mistreatment and violence during reproductive health care.

7.7 Training of Medical Staff

In the past few decades, student curriculums have included explicit teaching of patient-caregiver relationship, with an emphasis on informed consent. In addition, in recent years, patient-centered care has been increasingly emphasized in training programs of nurses, midwives and physicians.

However, on-the-job training programs do not necessarily reflect or include similar principles, and highly depend on individuals providing the information. Moreover, high-ranking staff members, who most often set the tone and culture of the departments due to

their position in the organization, might not have been institutionally trained in a culture that emphasizes informed consent as it is done nowadays.

7.8 Ministry of Health and Hospital Guidelines

Each hospital providing labor and delivery services employs its own birth management protocol. Unfortunately, these protocols are not published and therefore we cannot analyze them here. However, from women's reports in informal conversations and on social media, it is clear that these protocols most often promote a medicalized approach of birth. This approach can be illustrated by two birth management guidelines published by the MoH: the delivery room management guideline (31/2012) (see section 7.3) and the natural birth management guideline (15/2017).

Compared to the standard delivery room management guideline, the natural birth management guideline puts more emphasis on the woman's wishes, on the spontaneous process of birth, the delayed cutting of the umbilical cord, and non-pharmacological methods for pain relief. However, this separate guideline reinforces the medical approach in which natural childbirth is not the normal and regular track of birth. In addition, although it is meant to promote natural birth, it states many interventions as routine care, such as monitoring or infusion arrangements. Though more emphasis is put on the consent of the mother to these interventions, this should not be related to the birth track chosen by the woman. Furthermore, in some cases it is mentioned that the physician or the midwife will decide upon an intervention, while taking the woman's wishes into consideration. However, according to The Patients' Rights Act-1996, the woman should be the final decision maker regarding her treatment.

As mentioned earlier, women have to comply with specific acceptance criteria in order to enter a delivery room intended for the natural childbirth track. This restricts options for women who desire minimal interventions but do not fulfill the criteria. Even if this is not always practiced this way, these guidelines imply that those women can only choose the regular medicalized birth.

The Israeli MoH does not provide any recommendations related to rates of intervention or other birth management protocols, and refers to the Israeli Gynecologist and Obstetrician Association in these matters.

7.9 Childbirth and Reproductive Care Quality Indexes

Since 2004, the MoH has adopted the National Program of Quality Measures, which sets medical quality indicators in various medical fields, assesses their rate of achievement, and makes this information accessible to the public. In the area of pregnancy and childbirth, an issue relating to one of the widest segments of the patient population, only three quality indices were defined.

One quality measure concerns fertility treatment, another pertains to administration of antibiotics in the context of caesarean sections, and the last one refers to the percentage of

women asked to fill screening questionnaires of postpartum depression. There is not a single index that relates to vaginal births, to informed consent during childbirth, to the rates of interventions, to zero separation, or other birth outcomes.

Professional health and midwifery organizations (including WHO, ACOG and AWHONN) have already presented the need for quality indicators in the field and have even proposed measurable targets and aims. The adoption of these quality indicators in Israel can lead to a significant improvement in the quality of care offered to women and infants at birth.

7.10 Ethical Committees

In 2018, the Israeli MoH has published a guideline related to ethical committees. This guideline states that such a committee is mandatory in each hospital³⁹. This committee is authorized to deal with ethical issues raised by medical professionals as related to dilemmas they encounter in their day to day work, as well as cases where patients are not considered competent to provide informed consent (i.e. patients in coma or with severe psychiatric illness). They also deal with urgent treatment required where informed consent was not obtained.

As far as we know, issues raised in this document were not brought to such committees. The only related matters we know about that were dealt with in such committees are cases of women who refused cesarean sections while the medical team judged that it was required for the safety of the newborn. It has been brought to our attention that in some cases, the committee did decide the intervention was required despite the woman's refusal.

7.11 Recent Developments in Israeli Maternity Care

In the past several years, there has been a growing awareness of the need to provide women who are survivors of sexual assault and women suffering from post-traumatic stress disorder more individualized treatment. This is based on the understanding that some women might not be able to give birth in the regular system, and if not given an option for adaptations in their care, might choose not to give birth at all. As a result, new programs and services have recently opened their doors, and as such, in some hospitals, women can have meetings with staff before and after their birth⁴⁰. As far as we are aware, these programs do not offer continuous treatment, but they do provide an opportunity to identify and manage potential triggers in the delivery room, and promote a relationship of trust between the birthing person and the staff.

Recent conferences for maternity care providers have addressed the subject of treating survivors of sexual assault in the delivery room. These conferences include the recent annual conference of the Israeli Fetal and Maternal Health Association, the annual conference of the Israeli Society of Psychosomatic Obstetrics & Gynecology, and seminars delivered to medical

³⁹ Ministry of Health, (2018, Oct 8). Activity of Ethics Committees in Medical Institutions.

⁴⁰ Chaimovich, E. (2019 Mar 5) New in Kaplan: A unique staff of women will give support for birthing women who have experienced sexual trauma. *Arim News*

staff of maternity and delivery departments. These developments are encouraging and provide an invaluable service to women who might otherwise decide not to have children.

However, the discourse regarding survivors of sexual assault emphasizes the need to avoid re-traumatization, with little acknowledgement that human rights violations during birth can themselves result in trauma for women, whether they have a past history of sexual assault or not. Thus, this discourse, whether intentionally or not, diverts the blame for the initial trauma from medical staff onto laypersons and thus might discourage systems even further from putting accountability measures in place.

Another significant development in women's access to reproductive care is a guideline published by the Israeli MoH earlier this year, relating to the time women must wait for an abortion once they are made aware of in-utero death. Up until the publication of this guideline, women could have been forced to wait a week or two for the required procedure, since their case was not seen as a medical urgency. After several governmental committees and letters with testimonies, the Israeli MoH has published a guideline in which it states that a woman should not wait more than 72 hours for the required procedure⁴¹. Yet, we have already received some testimonies that this guideline is still not implemented in some hospitals.

7.12 External Initiatives

Following Keren Bria's report on gynecological examinations, the association has issued a charter for gynecologists to present in their clinic. The charter outlines the main recommendations and principles mentioned in the report. They have also been invited to speak in many hospitals, in order to present the survey results and represent women's voices. It is not yet clear whether this activity has managed to change practices in hospitals. However, it has been brought to our attention that in some community clinics there have been some changes in the care provided.

In addition, we were invited to give a guest lecture related to obstetric violence as part of a midwifery training program. Following the lecture, the course coordinator has managed to introduce this topic as a formal section of the program. However, it is currently very limited and consists of approximately two hours of the overall course.

Other important developments have been the Women Friendly Initiative and the establishment of the Birth Oriented Therapy approach. The Women Friendly Initiative aims to better communication between women and health care providers, with an emphasis on identifying and managing potentially triggering aspects of care. This initiative offers training for escorts who accompany women to examinations and help them come prepared. Birth Oriented Therapy is a professional therapy approach focusing on emotional and self-development processes in the period surrounding birth. As stated on their website, over 250 care providers from various birth-related professions have been trained in this method so far.

⁴¹ Ministry of Health, (2019 Jan 20). Treatment in Cases of Pregnancy Loss.

7.13 Addressing Secondary Trauma of Health Care Providers

In Israel, little to no data exists on secondary trauma or compassion fatigue as related to the medical teams in the field of reproductive health care and childbirth. However, we know from research around the world that this matter is significant and directly affects the care provided to women during childbirth⁴², as previous traumatic experiences of the team influence their clinical decisions and attitude. From informal discussions we have had with medical staff, we know that they do not have any professional emotional support related to this matter. They most often deal with these experiences by talking with each other.

A study by Halperin et al. (2011) explored coping strategies and challenges of midwives following childbirth situations they perceive as stressful. The researchers interviewed 18 midwives from 6 labor and delivery units in Israeli hospitals. They found that stressful childbirth situations may have a long-term impact on midwives, affecting both their professional and personal identities. The midwives that participated in the study expressed a need to implement a standard practice of processing traumatic or stressful events⁴³.

8. Accountability Mechanisms

8.1 Ombudsman Authority

As is stated on the MoH site, 'one of the Complaints Commissioner's roles is to rectify shortcomings at an organizational level'. Hence, 'the Commissioner recommends assessment of the shortcomings in order to provide an appropriate solution to the entire affected population. The Complaints Commission thus brings about change and rectification of shortcomings even in instances where many insured persons were unaware that the shortcomings adversely affected them'. Thus, it is within the power of the commissioner to bring forth large-scale organizational change. However, the office has not attempted to do so in the case of mistreatment and abuse of women during childbirth and reproductive health care.

In practice, from our experience, this accountability mechanism has not been found to be effective in addressing mistreatment and abuse during childbirth. Past complaints have been dismissed by the ombudsman as a subjective 'experience' of a rights violation instead of an actual rights violation.⁴⁴

⁴² Baas, M. A., Scheepstra, K. W., Stramrood, C. A., Evers, R., Dijksman, L. M., & van Pampus, M. G. (2018). Work-related adverse events leaving their mark: a cross-sectional study among Dutch gynecologists. *BMC psychiatry*, 18(1), 73.; Schrøder, K., Jørgensen, J. S., Lamont, R. F., & Hvidt, N. C. (2016). Blame and guilt—a mixed methods study of obstetricians' and midwives' experiences and existential considerations after involvement in traumatic childbirth. *Acta obstetrica et gynecologica Scandinavica*, 95(7), 735-745.

⁴³ Halperin, O., Goldblatt, H., Noble, A., Raz, I., Zvulunov, I., & Liebergall Wischnitzer, M. (2011). Stressful childbirth situations: A qualitative study of midwives. *Journal of midwifery & women's health*, 56(4), 388-394.

⁴⁴ Yoshefat, N. (reporter). (n.d.). *Obstetric Violence* [Television Broadcast]. Jerusalem: Here 11 [Kan 11] Retrieved from https://www.youtube.com/watch?v=a_guvfXxqr4

8.2 Responses to Complaints Regarding Separation of Mother and Newborn

The parent sponsored organization Zero Separation has been working from 2015 to increase the understanding and awareness of this subject amongst future parents. As a result, some parents send formal complaints to the hospitals about cases regarding separation of mother and newborn. However, these complaints are mostly left unaddressed, and there is no acknowledgement of wrongdoing on behalf of the hospital staff. The ombudsman is not involved in these cases at all.

8.3 Internal Institutional Reporting Mechanisms

We have only limited information on this topic, though it is of great importance and may play a crucial role in eliminating mistreatment and violence by staff members in health care settings. It has been brought to our attention by informal conversations that some attempts have been made by witnessing staff members to report repeated violations by other staff members to hospital management. As far as we are aware, this has not resulted in significant accountability measures taken in this matter.

9. Institutional Responses to Complaints

9.1 Official Responses of Hospitals and of the Ministry of Health

Official responses by the medical establishment to accounts of reproductive and obstetric violence depicted in the media have been varied. These included framing them as an issue of 'gender compatibility of medical services'⁴⁵; claiming to recall the incident differently⁴⁶; conveying sympathy for the complainant's feelings, but without assuming responsibility or admitting any wrongdoings⁴⁷; assuming responsibility in highly generalized terms, referring to future recommendations, with no acknowledgement of past rights violations⁴⁸; and declining to comment⁴⁹. At other times, the MoH has claimed to treat each case of violence reported to the office within the full severity of the law. However, in the same breath they have stated that to their knowledge, "not only is there no violence in delivery rooms, but

⁴⁵ Amaroussi, E. (2018, May 10). Cesarean Section, I Have My Hands Tied. Two Physicians Are Handling My Body and Talking about Soccer, *Israel Hayom* [Israel Today], weekend magazine.

⁴⁶ Limone, N. (2015 June 11). Insensitivity, humiliating treatment, medical risks. Has the medical system been systematically violating the rights of the birthing woman? *Haaretz*

⁴⁷ Yoshefat, N. (reporter). (n.d.). *Obstetric Violence* [Television Broadcast]. Jerusalem: Here 11 [Kan 11] Retrieved from https://www.youtube.com/watch?v=a_guvfXxqr4

⁴⁸ Ben David, M. (2018 Jun 24). The doctor yelled at the birthing woman: 'Shut up or I'll put you under [anesthesia]'. *Ynet*

⁴⁹ Limone, N. (2015 June 11). Insensitivity, humiliating treatment, medical risks. Has the medical system been systematically violating the rights of the birthing woman? *Haaretz*

rather there is a high satisfaction rate of women giving birth regarding medical staff members..."⁵⁰. This response does not take into account the highly problematic structure and timing of the satisfaction questionnaires administered internally by hospitals, as discussed earlier in section 7.6. It also ignores the myriad and complex obstacles that women who have experienced obstetric violence face in filing a complaint against a wrong that is oftentimes normalized by society at large. Accordingly, it does not address the proactive measures needed to be taken by the office in order to eliminate the abusive practices brought to their attention.

As was reported in a news article of May 2018, the MoH has established a committee for gendered medicine headed by Prof. Chen Shapira⁵¹. As far as we are aware, no recommendations have been published yet.

When a formal complaint is issued to hospital representatives and the MoH ombudsman, hospitals will sometimes offer a meeting with the head of the department or with the medical team themselves, mediated by the patient liaison or hospital risk manager. There is no acknowledgement that for the woman this is a process involving a risk of re-traumatization. Accordingly, there are no standardized measures taken to assure the woman maintains control of the situation. Usually, women receive a letter apologizing for the feeling and the subjective experience they have been through without affirming that there indeed was any violation.

It often seems that hospital representatives are not aware of the gravity of these events, and tend to either frame it as a standard issue of patient safety, or respond as if the reported rights violations are isolated incidents which have no relation to organizational structures and culture.

9.2 Official Responses of Professional Associations

Professional committees related to obstetrics and gynecology are under the Association of Obstetrics and Gynecology and include committees related to mother and newborn health, gynecological oncology, fertility, urogynecologists and others. Additionally, there is a midwife professional association and a home birth midwife association.

There have not been any official statements by professional associations explicitly mentioning 'obstetric violence', and few that have addressed this subject. However, in response to the report published by Keren Briaiah regarding women's perceptions of the gynecological examination, the Israeli Medical Association has issued a protocol regarding all intimate examinations. The guidelines include recommendations from Keren Briaiah's report that enhance patients' sense of privacy and control during intimate examinations. These include the covering of intimate parts during the examination, having a dedicated place where

⁵⁰ Even, D. (2012 Aug 19). Organizations for birth education have been fighting verbal violence by physicians. *Haaretz*

⁵¹ Amaroussi, E. (2018, May 10). Cesarean Section, I Have My Hands Tied. Two Physicians Are Handling My Body and Talking about Soccer, *Israel Hayom* [Israel Today], weekend magazine.

patients can put their clothes, locking the door during examinations, and avoiding physician judgmental remarks concerning the patients' choices.

Additionally, the Israeli Association of Obstetrics and Gynecology declared they are working on a document which will comprise all ethical principles to take into consideration during examinations.

Finally, the Israeli Nursing Management has also initiated a committee related to the emotional state of women surrounding pregnancy and birth, in which we were invited to speak and represent women's voices. We are still waiting for the publication of the committee's recommendations.

10. Restrictions of Childbirth Alternatives

Although there are no official figures related to the location of births, it is estimated that 99.5% take place in hospital, managed according to the medical practices and protocols in place. Only 0.5% of births are home births. It should be noted that alongside or freestanding birth centers are considered illegal as per local regulations. Home birth regulation is strict and is considered to be a private health care service provided by midwives and few physicians. Additionally, women who do not fulfill the guideline requirements will have to give birth at a hospital or give birth at home alone, as in such cases the MoH prohibits medical staff from attending.

The number of home births has been increasing over the years, both in Israel and worldwide. The first home birth regulation was published in 2008 and was updated in 2012. Before these regulations were issued, home birth midwives and obstetricians practiced as per their professional judgement and as per the regulations in place in other countries. As such, independent midwifery units were established, providing care for women who preferred to deliver out of hospital in an alternative location other than their own home. With the publication of the home birth guidelines, these birth centers were slowly closed down a few at a time by the MoH. This has continued until April 2017, when the closure of a birth center in Southern Israel generated a public campaign by social activists to enable birth centers as a birthing option, as is the case in most developed countries.

In February 2018, a petition was submitted by our organization with the owners of the birth center "Birthing Home" (*Beit Yoldot*), to the Israeli Supreme Court, seeking to regulate the opening of independent birthing centers, to strengthen the right of every woman to choose where she gives birth and the type of professional support she receives, as well as to enable freedom of occupation for those midwives who choose to practice outside of the hospital. This petition was discussed later that year, and in a majority vote of 2 to 1, the court has ruled against our request to enable birth centers in Israel. Our request for an appeal has been accepted and we are waiting to rediscuss the matter in court.

The main argument of the MoH has been that midwives provide medical treatment during childbirth that should only be given in a hospital setting. The petitioners claimed that birth is a natural event in the life of a woman and a family, and so it does not typically require any active interventions, but rather support and no interference in order to let the natural process take its course.

With home birth regulation being very stringent and birth centers being currently illegal, women are not left with a choice as to the location of their birth. In practice, hospitals have a monopoly on birth, which by itself represents a serious violation of women's autonomy.

11. The National Committee of Bioethics

In 2014, the National Committee of Bioethics decided to establish a subcommittee to address the issue of human rights at birth. The council's decision followed the publication of a guideline by the MoH in 2012, regarding home births, which caused repeated queries and extensive activity by our organization. The sub-committee interviewed representatives from the conventional medical system as well as professionals from the midwifery field, such as representatives of the Home Birth Midwives Organization (*IMAHI*), representatives of the National Doula Organization, and representatives of Women Call for Birth. The subcommittee continued to review the subject matter for more than 4 years, and to our delight it was published in May this year, with far-reaching recommendations, and has already made headlines⁵².

The position expressed in the position paper is quite revolutionary, as it contains an unequivocal declaration that the mother is the final authority regarding her birth, and that her decisions must be fully respected, including decisions regarding the place of birth. The paper explicitly states that the woman's decisions should not affect the quality of treatment provided to her. The position paper also recognizes the existence of two models in childbirth care: the obstetric and midwifery models, stating that it is necessary to provide the conditions for the coexistence of the two models in Israel to enable genuine freedom of choice for women. The significance of this declaration is that the committee considers it necessary to implement a continuous midwife-led model in hospital births as well as home births, to establish independent birth centers in Israel, and to make home birth available to all women in Israel. We will be happy to provide a translation of the full position paper upon request.

12. Barriers to Achieving Justice in cases of obstetric violence

For women who have been subjected to obstetric mistreatment and violence, the path to seeking justice is rife with obstacles. Here we will outline some of the obstacles women face at different junctures of this process.

12.1 Psychological and Societal Barriers

First and foremost is the struggle to make sense of an event of violence that is not recognized by society, but instead is deemed to be medical treatment. Many women are not aware of their rights during labor and delivery, and are not experienced with the hospital system. As one caller of the hotline said, "From the moment I heard the term 'obstetric

⁵² The Bioethics Advisory Committee of the Israel Academy of Sciences and Humanities, (2019). *Freedom of Choice and Human Rights in Childbirth*. (Position Paper No. 8). Jerusalem, Israel.

violence' I suddenly had a name for what [they] did to me. I thought it was normal. That this is how birth should look like."

When women first try to share their experiences with people close to them, they are often met with misunderstanding. This misunderstanding can translate into various unsupportive and critical responses. Examples may be questioning the woman's memory of the events; insinuating that the woman is overreacting, at the expense of her duties as a mother; focusing on her subjective experience while disregarding the objective violations that she has been subjected to; encouraging the woman to focus on future births, and what can be done to change the circumstances the next time around, as opposed to acknowledging her need to seek legal redress or some kind of closure regarding events that have perspired in the previous birth; or alluding to the luck involved in 'falling on nice staff', suggesting that this is an inevitable and acceptable aspect of the public health system.

Other dismissive responses relate to the characterization of the relevant staff members in casual or relatable ways as merely being rude, insensitive, or having bad bedside manners. Excuses are further made for their behavior, such as explaining that they were distracted or moody due to a busy shift; that they are used to the exposure of patients' bodies and thus desensitized; that they have performed a medically necessary procedure but simply forgot to obtain informed consent; or that they do not know any better.

This normalization of the events of the birth may leave women feeling misunderstood by their surroundings, a continuation of the sense of being transparent they may have felt during the birth itself.

Finally, the early phase of motherhood is highly time consuming and physically, mentally and financially demanding. Thus, it does not leave much energy left to pursue justice in these cases. As one caller said, "I assume it's too late to complain since it's been a few years since the birth... I wish I had the strength to complain at the time."

12.2 System Barriers

Even when women are aware, or become aware, that their rights have been violated, filing a formal complaint can be difficult for women who have experienced obstetric violence, and so, many women are reluctant to do so. Filing a formal complaint forces them to recount a highly intimate and humiliating experience. In addition, they often experience much uncertainty as to their rights in the process of filing a complaint. First, they do not know if they will be believed. After having suffered obstetric violence by employees of a formal institution, presented to them as legitimate medical care, many have lost trust in the system and its representatives. Furthermore, they do not know who will be privy to the details of their complaint. They do not know if they will be requested to come and speak in front of a panel of physicians as part of due process or be asked to meet directly with the staff members they have complained against. Some feel deep humiliation due to their vulnerability and helplessness during the incidence. Thus, meeting the staff members responsible for the violation of their rights may be re-traumatizing. Others, especially those living in rural areas without much choice of hospitals, fear an adverse response of the staff if they return to the same hospital for future births. Accordingly, some of the hotline callers expressed their concerns regarding the emotional stress involved in filing a complaint. One caller described her ambivalence about the idea, explaining that she did not feel mentally prepared, and was

afraid that it will reawaken the trauma that she was just now recovering from. Others mentioned having already complained to the hospital but receiving a dismissive response.

12.3 Legal Barriers

Women who wish to file a lawsuit for medical malpractice or assault face numerous legal barriers. We provide several examples for such challenges. It should be noted that this is not an exhaustive list.

In her article, 'Obstetric Violence', Elisabeth Kukura provides a thorough analysis of the failure of American law and regulation to provide legal recourse for women who have experienced mistreatment during childbirth⁵³. In her review, she describes characteristics of the current American tort system which hinder the ability of women to seek redress. Several of these characteristics also characterize the Israeli tort system.

As Kukura states:

'Attorneys act as gatekeepers to justice for patients harmed by medical treatment performed negligently or without informed consent. In the absence of financial resources to hire private counsel on a retainer, most women depend on counsel who are willing to provide legal services on a contingency fee basis.... attorneys are likely to decline to take on legal matters where they perceive insufficient damages will be available to cover costs and fees, or where they do not find the prospective client's claims compelling.'⁵⁴.

In addition, under the tort of medical malpractice, the physician's conduct is compared to the professional standard of care. However, as Kukura mentions, the guidelines serving as evidence for the standard of care do not necessarily reflect the best available evidence, and are inclined towards the medicalized model of childbirth care⁵⁵.

Moreover, in order to bring a civil lawsuit for damage, one must prove damage. Women may suffer significant emotional grief as a result of mistreatment in childbirth. However, they may display symptoms which do not amount to a full-blown mental health disorder as defined by the DSM-IV. It should be noted that the Israeli legal system is unique in its consideration of the violation of autonomy to be a separate head of damage, distinct from any physical damage due to negligence⁵⁶. However, the challenge of proving this damage still stands. In addition to the legal challenge involved, women are often reluctant to seek legal redress due to the stigma related to receiving a psychiatric diagnosis, which is required in the process.

Finally, as Israel is a small country, its professional medical community is tight knit. This may make it more difficult to find physicians willing to testify as medical experts in any malpractice case, let alone cases of obstetric mistreatment and violence

⁵³ Kukura, E. (2017). Obstetric Violence. *Geo. LJ*, 106, 721-801

⁵⁴ *Ibid.*, p. 781

⁵⁵ *Ibid.*, p. 783

⁵⁶ Jacob, A. (2012) Daaka – The Evolution of Injury to Autonomy. Hebrew U LR, 5.

13. Summary and Recommendations

In this submission, we have attempted to give a full account of the Israeli reproductive health care system in relation to the issue at hand. We have provided information of both incidences of obstetric mistreatment and violence, and of institutional practices aimed to prevent them. We have tried to convey a fair and complete picture as best as we could.

We are grateful for the many hardworking and compassionate professionals who work tirelessly to provide care for women during one of the most vulnerable moments of their lives. These care providers work long shifts with high workloads, and are exposed to trauma on a daily basis, with little institutional acknowledgement of the challenges they face. We see the changes we propose as benefiting all those related to the reproductive health care field.

Mistreatment and violence during reproductive health care is a grave violation of human rights, with severe implications on women and their families. It is caused and enabled by multiple psychological, societal, and institutional factors. We therefore propose a multipronged approach, addressing different interested parties of this issue. In addition, we present our recommendations to enhance the process of informed consent, as we have mentioned throughout this report.

First, we believe that raising awareness in the general public is a crucial aspect of eliminating this phenomenon. A combination of media attention and effective mechanisms for informing patients of their rights, serves as a prevention measure by empowering patients when receiving reproductive care. It is also needed in order to promote acknowledgement of the harm suffered by those whose rights have already been violated. This is crucial in order to legitimize women's traumatic experiences, ensure adequate support, and eventually enable the process of healing. This goal informs a significant part of our advocacy work.

We also recommend ongoing in-depth training of medical staff regarding the various issues related to this phenomenon. Such training programs should include topics such as the power dynamics between medical staff members and patients, including ways to mitigate it; a clear understanding of informed consent and informed refusal; real life ethical dilemmas; awareness of mental health challenges of staff, such as burnout, secondary trauma and compassion fatigue; and trauma-informed care. Most importantly, training should include a recognition of the existence of obstetric mistreatment and violence. In other words, the discourse relating to the violations in question should be reframed so that it reflects the severity of the consequences on women's lives.

At the same time, we propose to dramatically increase allocation of resources to maternity departments. These resources should be invested in providing a one-to-one ratio of midwife per birthing woman; providing training for all midwives and physicians about natural births (and human rights issues, as mentioned before); having additional anesthesiologists on call; reorganizing facility structures and having all the equipment required to enable free movement of women during labor; ensuring the privacy of women in labor while waiting to enter the delivery room; and providing care providers with professional and timely support for processing the potentially traumatic events they encounter during their work.

We also call for recognition and support of both the obstetric and midwifery model of care during reproductive health care and childbirth. This should include availability and

legitimation of both options according to the woman's choice. It requires development of midwife-led care in hospital, freestanding and alongside birth centers as well as including home births as part of the public health care system.

As we have mentioned throughout this report, we recommend several changes in existing mechanisms and practices. These include accreditation measures and quality indices regarding provider-patient relationship; informing birthing women of their rights at every juncture, due to the unique situation of birth as an ongoing and emergent process. This should be done throughout prenatal care and before every invasive examination; consulting with mental health professionals when phrasing hospital surveys for women; discussing birth options with women during routine prenatal care; including a standardized lecture about patient rights during childbirth in birth preparation courses; aligning consent forms with patient rights as they are defined in the law; and encouraging the inclusion of non-pharmaceutical and non-invasive practices for every birth. In addition, we strongly encourage further research on mistreatment and violence against women during reproductive health care and childbirth. We also call for routine external supervision and evaluation of delivery rooms by the state comptroller.

Finally, we emphasize the imperative need of putting in place clear, unequivocal, and effective accountability measures, including effective and publicized reporting mechanisms, in order to protect the physical and mental safety of patients during their most vulnerable moments. This is especially urgent for cases of major and clear-cut rights violations and for cases of repeat offenders, and it is paramount in order to rebuild the trust between women whose rights have been violated and the medical health care system.

We thank you for the opportunity to raise the voices of women who have experienced obstetric violence, and hope that you find this report helpful in your endeavors to eliminate this phenomenon.

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