The last thing women (and midwives) need is a shiny, new birth factory

Earlier this year, the UN Women's Committee, CEDAW, echoed by the Human Rights Commissioner of the Council of Europe, drew Ireland's attention to the need to bring maternity services into line with international human rights standards. Swiss human rights expert Patricia Schultz told the government that its highly centralised system of maternity care "transformed the most important experience of a lifetime for women and their partners into a production-line process". The resources the government plans to put into maternity care should reflect the commitment, she said, to respect the normal birth process.

The new National Maternity Strategy 2016-2026 enshrines this centralisation and, by extension, the production-line process it has given rise to. This is a system of care known as the "active management" of women in labour. Designed in the 1960s at the National Maternity Hospital at a time when the hospital was severely overcrowded, just as it is today, its effect is to maximise throughput in the labour ward. Active management involves rupturing the waters surrounding the baby in the womb, combined with administering an intravenous infusion of oxytocin, a synthetic hormone, to induce or accelerate labour. It is premised on involuntary medical intervention: no provision is made in the manual on active management for women to refuse these procedures. Judged by internationally accepted human rights standards, it is not fit for purpose in 2017.

This is a perspective that turns the controversy about the €300 million new National Maternity Hospital (NMH) on its head. The claim made by the NMH master Rhona Mahony about the "unarguable" need for what is to be the biggest maternity hospital in Europe rests on the assumption that centralisation is best. But if centralisation leads to industrialisation and industrialisation leads to the denial of women's human rights in the labour ward, then the last thing women (and midwives) need is a shiny, new birth factory.

There is a better and more cost-effective solution to overcrowding. Birth centres are a half-way house between home and hospital that provide a homely non-clinical environment. Run and managed by midwives, there are 43 such birth centres provided by the NHS in England alone. The evidence shows they are particularly suitable for low-risk healthy women, including those having their first baby, because the rate of interventions is substantially lower while the outcome for the

baby is no different compared with an obstetric unit. Furthermore, they generate greater cost savings compared to integrated MLUs, and there is a demand for them in Ireland.

In 2005, a randomised controlled trial involving the population of women registering for maternity care at Our Lady of Lourdes Hospital Drogheda and Cavan General Hospital found that 43 per cent were eligible for midwifery-led care. Of those, 54 per cent opted to join the study offering the chance of midwifery-led care in a unique, home-from-home, integrated MLU. Those findings were recently reflected in a survey of women's experiences of maternity care conducted in 2014 by AIMS Ireland. Among 2,836 women, 58.5 per cent said they would opt for a freestanding birth centre if the service were available. This evidence shows that of the 9,186 women who gave birth in NMH in 2015, some 2,132 (23%) were eligible for, and would most likely have opted for, birth centre care had the option been available.

This compelling evidence on safety and cost-effectiveness of birth centres under midwifery-based care begs the question as to how the National Maternity Strategy could come into effect without providing for this key option of care for which there is established demand. What it enshrines points to the politics of power and money over health benefits: in essence, a safe-guarding of medical incomes. The unfettered influence and control of consultant obstetricians on maternity care policy in Ireland fundamentally obstructs the development of midwifery and choice in childbirth, and is a crystal clear strategy in safeguarding the obstetric monopoly of the lucrative Irish maternity care market.

There is an onus on the Minister for Health to have regard to his obligations under international treaties to uphold the human rights of women and girls in maternity care. The more maternity services are centralised into larger hospitals, the greater the need for uniformity and predictability in birth to avert a labour ward bottle-neck, and the more remote the possibility that women can give birth at their own pace. If women's rights to bodily integrity, self-determination and autonomy were respected in labour and birth, the centralised, medicalised production of babies would be unsustainable.

Investing €300 million in a huge new 10,000 births per annum maternity hospital providing extensive facilities for private medical practice in the absence of any investment in infrastructure at community level to develop midwifery-based care flies in the face of women's human rights in childbirth.

Philomena Canning | Chairperson

Midwives for Choice

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