Question	Answer
Asset ID	714034
Page 1	
Title	Mrs
Please specify your title	
Given name	Azure
Family name	Rigney
I do not wish to provide my name	
Contact number	
I do not wish to provide a telephone number	
Email address	qld@maternitychoices.org.au
I do not wish to provide an email address	
Street address	
Suburb	
State	
Postcode	
I do not wish to provide a postal address	I do not wish to provide a postal address
What type of submission are you making?	I am responding to Discussion Paper 3 and making a general submission
Who are you making the submission for?	I am providing information on behalf of an organisation or institution
What is the name of the organisation?	Maternity Choices Australia
What is the core work of the organisation?	Advocacy
What is your position in the organisation?	Qld President

Question	Answer
Do you have authority from the organisation to make a submission on its behalf?	Yes, I am authorised to make this submission on behalf of the organisation I represent
Please specify who you are making this submission for	
Please select at least one from below	
Please specify (if **Others** was selected)	
Are you able to advise a timeframe for when most of the lived experience/observations in your submission occurred?	In the past two years

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How would you like us to use your information?	Identified – published on website

Page 3

What is your age range?	I am between 26 – 35 years old
What is your gender?	Female
Please specify other gender	
What is your current postcode?	4066
What is your main language other than English spoken at home?	No
In which country were you born?	Australia
Do you identify as a member of any of the following groups? (Please tick all that apply)	Person with disability

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Your knowledge and experiences	Background adaptation from 'Reclaiming Childbirth as a Rite of Passage' by Queensland's Dr Rachel Reed. Ownership and war. During the early rise of the Patriarchy, land ownership passed down the paternal line from father to son and it became necessary to guarantee the paternity of their children, requiring ownership of women and the control of their reproduction. Unlike in hunter-gatherer times, children were no longer the responsibility of the tribe, instead, women became the primary carers of their older children as well as their babies. However, for a short while, women retained control over childbirth as a female only domain due to extensive knowledge about herbs, fertility, abortion, contraception and labour pain. Regardless of the socioeconomic hierarchy, women had lower status than men in each layer or

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	stratification. Kings mobilised men to fight in battles to protect their lands and women were expected to produce sons to replace them. On capture women were a valuable resource, raped by their captors and kept under surveillance to ensure the paternity of resulting children. Religion and State. Many religions claimed the subordination of women by men was sanctioned by God and that man should have dominance over nature. 5000 years ago governments began to form and laws were developed and influenced by patriarchal social structures and religious ideologies of the time. Laws relating to women's reproduction were similar across states and made adultery, contraception and abortion criminal offences. The punishments were not based on concerns about the life of the child as infanticide was common and legal if carried out by the father of the child. Wise women and medicine men. Universities reinforced religious and cultural ideas about the inferiority of women, however, used science and claims of rationality rather than religious doctrine. Male physicians were supported by church and state, enabling them to position themselves as the only legitimate medical practitioners. Royal, religious and academic decrees restricted the practice of medicine to licensed physicians only. A licence could only be obtained after completing university education to gain a formal qualification and clerical vow. Women were unable to access either as male physicians also persuaded the English parliament and King Henry to legislate the banning of women to practice medicine and surgery. Unlicensed practitioners, including women (midwives), were permitted to provide healthcare within a limited scope and charge small fees without advertising. Midwifery continued as it wasn't considered medical practice so male physicians set about defaming wise women and their services through the church and 'witch-craft'. They blamed sorcery when university-learned medicine failed to cure ailments citing witchcraft is the 'single greatest threat to Christian European civilisation'. Women who lived independently of men, widows and spinsters were targets. Male physicians participated by providing medical expertise regarding whether a woman was a witch or not. This often involved carrying out invasive physical examinations of the women's body. The witch hunts executed thousands and tortured more, but the systemic persecution of witches generated fear and silence among women, eliminating the majority of wise women. This paved the way for male physicians to step into high risk childbirth and place regulation through church and state on midwives in the 1600's, despite no training in childbirth of any risk status. In the 1700's childbirth was seen as a mechanical process, in which men are mechanically minded. Forceps were invented by a male barber surgeon, for complicated birth, but women were banned from using them. The use of technology in conjunction with science increased the status of male birth knowledge and helped to facilitate the eventual move into uncomplicated birth in the 1800's and into the present day. Industrialisation and Institutional maternity care. Medical knowledge around matenity care continued to be constructed around sex based sterotypes. Women are capable of creating children so it was perceived as their primary biological role and were considered feeble of mind and victim to their reproductive urges. Female disease and illness were explained as symptoms of women resisting or denying their 'biological destiny'. Rational male medicine purported to be able to diagnose, treat and control women's disordered bodies. Industrialisation led to crowded living conditions and increased ill health and injury. Hospitals were established to provide large-scale medical care where patients could be managed by doctors and tended to by nurses. They provided free care to poor women and obstetric training for doctors and nurses. Rates of childbed fever were high as doctors spread bacteria from ill and dead patients directly into birthing women's vaginas. The rates of maternal death remained high until the discovery of antibiotics in the twentieth century. Initially the rate of injury and death rose as hospital birth increased but over many decades all classes of women used services. Hospitals and medicine provided pain relief and a sense of 'safety' that filled the vacuum created by collapse of the collective birth culture of women. Many first wave feminists considered the option of medicalised hospital birth as a means of women gaining control of their own body and reproductive life. Hospital practices were also influenced by the mass production concepts of industrialisation. Women's bodies were managed as though they were on a production line, with routine interventions aimed at making the birth process more effective and efficient. Standard interventions were humiliating and dehumanising, including a public shave, enema and bath, followed by rupturing the amniotic sac with an amnihook. Narcotics and sedation were then administered to induce a 'twilight sleep', and women were strapped to beds to avoid injuring themselves as they thrashed about partially conscious. As the baby's head appeared, medicalisation (such as ergot) was injected to increase contractions and forceps were often used to remove the baby from the unconscious woman. Medicine forged an alliance with nursing to bring midwifery under the legal and disciplinary control of

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	medicine. Various strategic legislation resulted in midwifery becoming a branch of nursing rather than the separate profession it has always been. Traditional midwifery evolved from autonomous wise women whereas nursing had emerged to support medical practice. Midwives were socialised to become a nurse first, then taught the knowledge and skills of medicalised birth. Moreover, midwives could not regulate their own profession and medicine had a dominant voice in government, that we still see today through no Chief Midwife positions in Australian States or Commonwealth. Evidence based medicine emerged in the 1970's but did not become firmly established in healthcare until the early 1990's. Obstetric resistance to implementing research findings into practice was well known among other specialties of medicine. Routine interventions such as fetal monitoring, breaking the amniotic sac and episiotomies were introduced as part of the general medicalisation of childbirth, without any supporting research evidence. These interventions continue to be practised today due to maternity services focusing on cultural practice, in direct opposition to best evidence. This overview has explored the key aspects of herstory that forms the warp our birth culture is woven through. These threads will be revisited throughout this submission because current birth culture, knowledge and practice reflects the herstory of women and birth and women's status within society; dirty and malfunctioning versions of the superior male body. It will make it clear to readers that obstetric violence is a form of sexual violence and should be identified as such in modern law rather than remain a barrier for women to enter the criminal justice system and weave our future in sexual and reproductive bodily autonomy. What is sexism? Medical news today states 'Sexism is prejudice or discrimination based on sex or gender. It affects every level of society, from institutions and governments to personal relationships'. Sexism begins with prejudices. A prejudice is a bias against a person or group of people. It is often based on myths, stereotypes, and generalisations that a person learns from others. Biases about sex and gender can be explicit, something that a person is aware that they have. And they can be implicit, in which case, a person is not consciously aware of their biases. Sexual harassment The event, and additionally speaking about lived experience of sexual harassment can make people feel uncomfortable, scared, and even traumatised. Even if a person does not feel physically threatened at the time, it may cause or reinforce a fear of walking alone, wearing certain clothes, or being sexually assaulted. We see this in 'Canary in the Coal Mine:birthing outside the system' book by Professor Hannah Dahlen et al. The Qld Anti-discrimination Act Review discussion paper advised that sexual harassment can include a one off act. Authors agree that obstetric violence (OV), like all forms of sexual violence can be a one off, begin with gaslighting/grooming for compliance or at each contact. On 19AUG21 we supported a consumer who was digitally raped by a stranger midwife 20 mins before birthing her child seek legal advice from Legal Aid Queensland. The Lawyer advised this event would fall under sexual harassment. Systems support perpetrators to continue to practice (even if they are being investigated for a series of alleged abuses) as there is no transparency with hospital performance reviews, OHO, QHRC or AHPRA for the public or individual women involved in their 'care'. It is likely that many clinicians are routine violators of discrimination and human rights law. What is Obstetric Violence? The definition of obstetric violence is Obstetric violence is normalised mistreatment of women in the childbirth setting. It is an attempt to control a woman's body and decisions, violating her autonomy and dignity. It has also been termed "disrespect & abuse" or "abuse and mistreatment" by the World Health Organisation. The appropriation of a woman's body and reproductive processes by health personnel in the form of dehumanisation treatment, abusive medicalisation and pathologisation of natural processes involving a woman's loss of autonomy and of the capacity freely make her own decisions about her body and her sexuality which has negative consequences for a womans quality of life. It can also be explained as the intersection between institutional violence and violence against women. These are real experiences from Qld women; -denial of treatment (refusing access to Birth Centres and public homebirth particularly as these things help to prevent poor outcomes) -verbal humiliation (you can't have a waterbirth because your so overweight you can't get out of the birth pool) -Physical violence (clinicians asked security guard to hold her down) -invasive practices (midwife spread her legs without consent, doctor ripped down her bra and grabbed her breasts and said too small, you won't be able to breastfeed) -unnecessary use of medication (66% of women are cut open via c-section or episiotomy, this is obviously unnecessary and backed up by the Australian Healthcare Commission on Safety and Quality in Healthcare's 3rd atlas on 12 fold variance in c-section rates and other unwarranted interventions) -disregard for the woman's needs and pain (Qld doesn't offer pain relief options like homebirth) -forced and coerced medical procedures (49% have inductions and about 15% are necessary so we

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	estimate 30% are coerced and 4% is maternal choice) -detained for failure to agree or to comply (being told they aren't allowed to leave until they have a vaginal exam in pregnancy) - dehumanising or rude treatment (a women was sterilised without consent and she wasn't told until her 6 week postnatal checkup) Sex based oppression Unique to gender (which is a societal construct based on narrow sterotypes), reproductive harm can be seen throughout history based on biological sex. Maternity consumer advocates are not paid, this is an example of sex based oppression, so that we can not make as many submissions as we would like, make less political representation, less 1:1 support for consumers who are struggling to navigate the system including complaints to seek justice for the abuse and mistreatment they have endured. When comparing to Dept of Veterans affairs who give $11B/year to veteran advocacy organisations for 1:1 advocacy and psychosocial supports plus $1M pay out for severe PTSD as 1 in 5 veterans have PTSD. 1 in 5/10 women have PTSD, there are no funded 1:1 advocates, no 2 page claim forms, no compensation and trying to complain/litigate is a mess. Women's health has ⅓ the research budget as men's, so again we are performing procedures without having ever studies the female anatomy ie the clitoris was studies initially in 2005 but we have been cutting into clitoral nerves for decades routinely causing short and ling term harm. Non-evidence based care and acquired harm Most women are allocated to fragmented maternity services. Standard care is known for allowing most women to fall through the cracks. This prevents women from building a trusting two-way relationship, leading to higher interventions rates [10]. Unnecessary procedures, such as rapidly rising episiotomy rates, have a negative physical and emotional impact on the mother and her family. The WHO states no population should have more than 10-15% c-section and 10% episiotomy rates, but in Qld, the rate is 37% and 25%, only 38% get through facility based birth without being cut, with no improved outcomes for mum or bub. Further, Qld Health's Safety and Quality Executive has just released a Memo to all hospital CEO's endorsing the 'Perineal Bundle' clinical care standard as per Australian Safety and Quality Commission which recommends all (310,000 a year) women under go an anal exam to 'find' severe tears, but only 6 were found. Given 25% of women have experienced vaginal or anal sexual assault, we find the recommendations barbaric. Bureaucrats advise that women can say no, but clinicians in 1:1 care do not routinely offer benefits/risks/alternatives/intuition/nothing, and in fact the opposite occurs as most women advise on social media it is done without affirmative or informed consent. This is more likely to occur with a stranger care provider than a known one. Keedle 2022 shows that most maternity service users are abused and mistreated. Pregnancy inherently increases vulnerability The AHRC lists the many of their complaints centre around sex discrimination and harassment, when pregnant women are uniquely vulnerable. Public maternity services have a clear monopoly and women feel they have no choice but to enter the service, no matter how inappropriate or abusive. During recent Qld floods, government MP's advised 'Looting people when vulnerable carries a maximum prison sentence of 10 years'. We think a realistic sentence for maternity clinicians inflicting OV would be greater than 10 years as bodily autonomy is clearly more important than material possessions, the law just hasn't caught up in recognising women should have greater value than a stolen household item. One State Government MP suggested that women who experience abuse in birth should report to the Police, but remained silent when questioned further by advocates on if he really expected them to drive from the hospital to the Police station with their cut open vagina's or belly's, shaking with psychological injury and trying to feed their newborn baby who will also become a victim of OV by default. Women are uniquely vulnerable and we can not expect them to jump through the same hoops as other populations. Current complaints process and legislation is not fit for purpose. Mental Health impacts The degree of obstetric intervention experienced during labour has repeatedly been associated with the development of acute trauma symptoms throughout the postnatal period, which is a cause for significant concern [13]. For example, 33% of women are traumatised, 25% with PND and 10-20% with PTSD from their experience in the maternity system. From these figures 75% are directly related to care providers "threats, lies, coercion, abuse and violation" to comply with procedures [14]. In a Spanish study released this year, 67% of women reported obstetric violence, and 54% reported physical obstetric violence such as coercion and assault. We expect Australian figures to be similar based on the United Nations Special rapporteur's report on Obstetric Violence, where Australia was called out as a poor performer [4]. Women are so poorly valued, we don't even ask them about their experiences of obstetric violence or compare outcomes per facility or model of care. Education The Dept of Education Qld responded to our letter asking for respectful relationships in schools to include bodily autonomy in a healthcare setting, advising our volunteers should contact individual

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	Principals. An eerily similar format as Health Ministerial responses advising volunteers to go to individual hospitals and ask that staff adhere to their obligations rather than the Minister making a directive to adhere to legislation. Friends and family "At least you have a healthy baby!" from a loved one makes it very clear how little we are valued as the person giving birth. When we so desperately want to trust that our schools, hospitals, state boards, and courts will protect us, the reality can be excruciating: to discover that, even when you have finally found the strength to use your voice, you have not yet reached a safe place. How jarring to realise the burden of proof is on you, about an event for which no evidence is likely to exist beyond your own words, and you will be required to advocate for yourself yet again in the reporting process. Indeed, the accountability systems in place are neither very effective nor attuned to people (disproportionately women) carrying trauma from living in a patriarchal society. Peers Not funding maternity consumer organisations as a further sign of embedded systemic abuse, despite being the largest service user group and biggest spend. Other specialist health advocacy groups get upto $150M/yr in core funding for health promotion and consumer advocacy. The largest Hospital and Health Service in Qld has removed maternity consumer representatives from their Community advisory board in order to avoid discussing maternity in their strategy (Barnet 2020). The Qld women's strategy omits meaningful maternity data on sexual and reproductive violence such as unwarranted episiotomy and c-section rates and certainly doesn't touch on hospital acquired trauma or abuse and mistreatment experienced by women as there is no routine data collection or even appropriate 'Patient' Reported outcomes and experience measures for women to share their story. There is no data collection on who missed out on their choice in model of care or place of birth (80% miss out on model of care and 100% miss out in choice of birthplace), its crazy this is not collected when these two 'choices' are the biggest predictor of poor outcomes. The hospital itself Hardly going to dob themselves and their staff in. Yet this is the only 'advertised' method of seeking justice, and when I say advertised, 90% of consumers who contact us say 'I didn't know I could complain'. No hospital lists QHRA 2019 complaints process on their websites or on any forms for consumers to become aware of processes outside of litigation. The Current legal process for 'justice' Litigation is hard work and expensive. Many lawyers have no idea what OV is let alone how to seek justice through various possible avenues but none are fit for purpose and this has never been done before on a large scale. Fragmented services Qld Health has no oversight on what is happening in each hospital as they are separate public entities. They have no mechanisms to gather themes. They have been asked to dictate at DDG/DG or ministerial/assistant minister level, but have advised they will not be adopting the recommendation to collect data on women's experiences of OV. Police, reporting does more harm than good Qld police service, like come on. Do we really expect a woman with a 12 hour old baby to report to the local police station after being sliced open without consent? There are 4 traumas that happen when an assault occurs. The first is the event itself. The second is telling someone. And the third, when people you trust don't believe you about it. When you can't get justice. Department of Children's Services, a tool for compliance Child protective services, a real risk, but used as a tool to gain compliance and silence so that women don't speak up about their experiences of abuse and mistreatment. OHO, very low standards When reading reports from the Office of the Health Ombudsman, advocates summarise the findings as 'old, fat, victim shaming' rather than any genuine interest in protecting the public (pregnant or postnatal women). It is overwhelmingly clear most public servants do not understand maternity evidence and how restrictions on their bodily autonomy causes harm. They believe harm reduction like homebirth is an extra service, they don't understand that hospitals cause harm (1:10 patients are harmed and 9:10 maternity consumers are harmed in hospitals). Human Rights, a violation has already occured QHRC offer consumers a complaint mechanism for harmed women, however they must have already suffered the consequences of the human rights violation. Thus the act doesn't prevent harm, which we would like to see occur with OV legislation. Medical Negligence is wholly inappropriate Women are completely burned out and rarely take claims down the medical negligence route. Their experience feels like duplication and added time, money and stress. Within the legal community, it is well known how paternalistic civil liabilities act, particularly here in Qld. A women with experience of an unconsented anal exam post birth (digital anal rape), would not be supported to litigate. Since the introduction of a non evidence based 'clinical care standard' called the Perineal Bundle, a sharp rise in anal assault is being reported to us. We have supported women with this enquiry with some law firms last year. They advise women must suffer long term physical injury from the assault in order to successfully claim given expert witness etc fees are so great.

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	Case Studies Case Studies: complaint around coercion (no water without VE), threats and physical assault, the hospital's awful response, advocacy organisations letter to the ACSQHC and their refusal to act. - was coerced into DS screening and received 26 threats to abort her baby from clinicians - refusal to allow her husband to support during abortion - Sexual assault victim with PTSD reported to police and man in jail, anal exam without consent in labour and re-triggered PTSD, didnt know who to report it to - episiotomy without consent - consent for VE but Stretch and Sweep was performed without affirmative consent - Coerced into being on back and episiotomy. Pulled on cord without consent and caused large bleed making her 'high risk' for subsequent pregnancies but no event occured in subsequent pregnancies due to protective factor of known midwife and homebirth - stood on her arms so she had to lay in her own vomit pleading to help up - bullied, physically forced onto back, forced , forced catheter, Episiotomy, unnecessary Vacuum - unknowingly swabbed for GBS around 25 weeks and then was told couldn't have a water birth; rough and painful internal examinations during labour by unknown midwife -resulting in months of vaginismus (painful sex) postpartum; emergency c-section due to failure to progress in pushing stage (despite both mum and bub not being in distress) - induced as there would be no doctors around on the weekend if labour commenced. Resulted in an emergency c-section - Undetected major internal anal tear -only getting a proper diagnosis one year on and requiring surgery. In summary, criminalising sexual violence with a specific reference to obstetric violence is welcome.
Upload file	