FIGO Human Rights and Women's Health Case 7 Discussion
An unwelcoming birth facility

This case highlights the right to nondiscrimination, which lies at the core of almost every international human rights treaty. Nondiscrimination, among other requirements, obliges health providers to respect patients and their views and not to impose their own personal beliefs on them. International human rights law expressly prohibits discrimination on the basis of sex, race, ethnicity, language, religion, disability, and economic status, among others. Human rights bodies have recognized additional grounds of discrimination on the basis of age, actual or perceived sexual orientation and gender identity, marital status, health status (including HIV status), and pregnancy. Women who are also members of a vulnerable or marginalized group may face multiple forms of discrimination. The right to nondiscrimination requires states to eradicate discriminatory policies and practices and to take affirmative measures to ensure that everyone is afforded the same rights in law and in practice (CRR, UNFPA 2013).

Learning objectives

For physicians to competently apply this principle to daily practice they must be able to:

- Discuss how principles of nondiscrimination result in improved health for everyone.
- Discuss the impact of societal and cultural roles and religious practices on health care.
- Discuss the extent to which women are assured of receiving appropriate care in maternity services.
- Provide optimal health care services and establish mutually respectful relationships with men and women of all backgrounds and abilities.

Note that although the case highlights the right to receive care free from discrimination, it also addresses a variety of other ethical, human rights, and policy issues. Similarly, although the medical issues of the case focus on complications of postpartum hemorrhage, the standards of practice are applicable to many medical emergencies/situations.

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Case study

At 36 weeks into her second pregnancy, A.R. is still undecided about where to deliver. A.R.'s midwife at the primary health center strongly encourages her to take up residence at a local hospital maternity waiting home where she delivered her first child. That delivery was complicated by a severe postpartum hemorrhage. A.R. is reluctant to make the 50-kilometer journey to the maternity home because of her previous experience with the hospital's religious policies.

The hospital is faith based but receives 20% of its annual funding from the state in return for providing public services. Hospital policy requires that all residents of the maternity home attend Sunday church services in the hospital's chapel, where only the religion of the hospital founders is recognized. A.R. does not practice that religion and finds the services disturbing. During her last pregnancy, she requested to be excused from Sunday services and was accused of being ungrateful for the free lodging and meals provided to her during her stay. Her pregnancy care was excellent but she felt humiliated by the experience.

This time she does not go to the maternity waiting home. At 38 weeks, A.R. goes into labor and within 3 hours she delivers a healthy daughter at the primary health center. She again bleeds profusely when the placenta is delivered. The clinic midwife gives her an injection of oxytocin and applies compression while waiting for the ambulance to arrive to take her to the hospital. Still bleeding, A.R. is transferred to the same district hospital where her first child was born. Upon arrival, the doctors pronounce her dead of exsanguination. The pastors give her body the blessings of the church and release it to her family.

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Questions for discussion

1. What are the medical issues of this case? Specifically:

a. What are the possible complications during the delivery of a woman who has a history of postpartum hemorrhage?

Women with a history of postpartum hemorrhage are at increased risk of recurrence with subsequent pregnancies. The complications of each episode of heavy bleeding with delivery are anemia and shock from the bleeding, endometritis and sepsis from the interventions, and death if either complication progresses.

b. What is the appropriate antepartum management of a patient with previous postpartum hemorrhage?

During routine prenatal care, it is appropriate to discuss delivery in a facility with first-level emergency obstetric care. Women who live distant to such a facility, especially those without transportation for emergency care, should be encouraged to move nearer to such a facility from 37 weeks to await delivery. A mothers' waiting home is one way of ensuring this.

In addition, efforts must be made during pregnancy to prevent or treat anemia. Hemoglobin level should be above 11 g/dL at full term.

c. What is the appropriate management of acute postpartum hemorrhage?

As with any emergency situation, begin with basic lifesaving measures to maintain airways, breathing, and circulation. Provide oxygen supplementation and resuscitate the patient with intravenous fluids and blood products using two wide-bore cannulas.

With the patient hemodynamically stable, determine the cause of bleeding. If uterine atony is the cause, use uterotonics (oxytocin, ergometrine, or misoprostol) to achieve uterine contractility and hemostasis. Surgical procedures such as uterine compression, insertion of a balloon into the uterine cavity to effect tamponade, or compression sutures such as the B-Lynch can be used if the primary interventions do not work. Hysterectomy may be necessary for persistent cases.

If the bleeding is the result of birth canal injuries or retained placenta, surgical repair or evacuation should be attempted once the patient is stable.

2. Using the Integrating Human Rights and Health Checklist, identify the human rights that were infringed in this case.

When a patient is required to comply with a hospital's religious policies or practices, regardless of her own beliefs, numerous human rights are implicated. These rights include the right to nondiscrimination (on the basis of religion and sex), the right to life, the right to health, the right to be free from inhuman and degrading treatment, the right to respect for private life, the right to autonomy, the right to freedom of conscience and religion, and the right to the benefits of scientific progress and its applications. Policies and practices that place undue onus on women in order to access comprehensive reproductive health care constitute discrimination.

The rights to nondiscrimination and equality are guaranteed protections in the exercise of all other rights. They require states to eradicate discriminatory policies and practices and to take affirmative measures to ensure that everyone is afforded the same rights in law and in practice. Furthermore, states must take measures to combat the social and cultural beliefs that contribute to the diminished status of women worldwide and that have a negative impact on their sexual and reproductive health (Center for Reproductive Rights and United Nations Population Fund 2013).

3. How did the policies for religious observation at the maternity home cause discrimination against A.R.? What were the health consequences of that discrimination?

States have a human rights obligation to guarantee access to timely, nondiscriminatory, and appropriate maternal health services. In considering the case of maternal death, the United Nations Committee on the Elimination of Discrimination Against Women (CEDAW) found that "[t]he lack of appropriate maternal health services in the State party that clearly fails to meet the specific, distinctive health needs and interests of women … constitutes … discrimination against women …". The committee stressed that even when governments outsource health services to private

institutions, they remain directly responsible for their actions and have a duty to regulate and monitor these institutions (CEDAW 2011).
In A.R.'s case, coercion to attend religious services resulted in her avoidance of care from the hospital that could provide the best technical care for her as a high-risk patient. The state's failure to fulfil its obligations to secure access to appropriate health care, including by private hospitals, and the hospital's discriminatory practice resulted in her untimely death.

4. What laws and/or policies of your state or country protect against discrimination in health care settings?

In most countries nondiscrimination clauses are included in the constitution and are regulated by health care laws and policies. This case is challenging because the hospital as a private organization may make policies consistent with its religious affiliation. Private faith-based facilities that operate as public service providers, should consider the impact of their requirements on patients. As noted above, states that outsource provision of health services to private institutions, including by co-funding a facility, are directly responsible for their actions and obliged to ensure that the private institutions provide appropriate care free from discrimination.

Students and teachers discussing this case should be aware of the faith-based facilities that provide health care in their region and become familiar with these facilities' policies. Where rights are being violated, they should consider that physicians have an obligation to address such rights violations.

5. How might the system of maternity care offered by this district hospital balance the rights of women with the hospital's faith-based interests?

Consistent with international human rights standards the state should regulate the facility to ensure it provides lawful reproductive health services, including comprehensive maternal health care. Additionally, the governing board of the church running this facility needs to reconsider its policies to eradicate the discriminatory requirements for receiving health care.

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