Queensland Human Rights Commission
Submission to ADA Review
Emailed to: adareview@qhrc.qld.gov.au
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Maternity Choices Australia appreciates this opportunity to contribute to the Queensland Human Rights Commission's review of the Anti-Discrimination Act Qld (1991). Given resource constraints, we have responded to selected discussion questions, as listed below. In summary, we support that

- the 'unfavourable treatment' approach be adopted (Discussion question 2)
- the 'disadvantage' approach be adopted (Discussion question 3)
- there is a need to protect people from discrimination because of the effect of a combination of grounds (Discussion question 7)
- additional words "in the presence of a person" be added to the meaning of sexual harassment in the Act (Discussion question 9a)
- a further sex-based harassment contravention be adopted (Discussion question 9b)
- the Act explicitly prohibit creating an intimidating, hostile, humiliating or offensive environment on the basis of sex and that this should apply to all areas of activity under the Act, including the provision of reproductive health and maternity services (Discussion question 9c)
- a direct right of access to tribunals be included (Discussion question 10)
- the time limit to lodge a complaint be extended to at least 2 years (Discussion question 14)
- the introduction of a positive duty would cover all forms of prohibited conduct and apply to all areas of activity, including the provision of reproductive health and maternity services (Discussion question 21)
- Sex is retained as a protected attribute (Discussion question 35)
- Non-profit goods and services providers of reproductive health and maternity services should be included in the Act (Discussion question 52)

**MCA also recommends that QHRC considers incorporating the explicit prohibition of another form of sex-based discrimination 'obstetric violence' into the Act (Refer Discussion question 9d).**

The mistreatment of women by reproductive health and maternity services is a longstanding and complex problem that is a form of sex-based discrimination. However, due to harmful gendered stereotypes about women's bodies and their inferior status within society, this behaviour is often normalised and rendered invisible within reproductive health and maternity services contexts. We consider that pregnant women and mothers would benefit from having 'obstetric violence' explicitly prohibited in the Act, in order to encourage entities that provide reproductive health and maternity services to take proactive and preventative actions to address this longstanding form of sex discrimination and violence against women.

**Azure Rigney**
**MCA Queensland President**
[redacted]

**RESPONSES TO DISCUSSION QUESTIONS**

**Discussion question 2:**

**Should the test for direct discrimination remain unchanged or should the 'unfavourable treatment' approach be adopted?**

The widespread mistreatment of pregnant women and mothers by entities providing reproductive health and maternity services often occurs based on a combination of multiple protected attributes possessed by childbearing women, including, but not limited to, sex, pregnancy and/or parental status. We would support the 'unfavourable treatment' approach being adopted as the existing 'comparator' test for direct discrimination is less easily applied in circumstances relating to the provision of reproductive health and maternity services.

**Discussion question 3:**

**Should the test for indirect discrimination remain unchanged or should the 'disadvantage' approach be adopted?**

We would support the 'disadvantage' approach to be adopted.

**Discussion question 7:**

- **Is there a need to protect people from discrimination because of the effect of a combination of attributes?**
- **If so, how should this be framed in the Act?**
- **Should other legislative amendments be considered to better protect people who experience discrimination on the basis of combined grounds?**
- **What are some examples where current law does not adequately protect people from discrimination on combined grounds?**

As outlined above in response to **Discussion question 2**, the widespread mistreatment of childbearing women while interacting with entities providing reproductive health and maternity services often results from intersectional discrimination, based on the combination of protected attributes possessed by childbearing women, including sex, pregnancy, breastfeeding and parental status. Other forms of discrimination based on age, race and culture are also more prevalent when health services employ fragmented, industrialised models of care, rather than relationship-based care models. We support the need to protect people from discrimination resulting from the effect of a combination of attributes.

**Examples where the current law does not adequately protect people from discrimination on combined grounds**

West Moreton Hospital and Health Service (HHS) received approximately 2000 complaints from women regarding their experience of maternity services on social media in late 2020. After several attempts, 80 women were able to access the online complaints form. The HHS reported on their summary of the issues; including age discrimination but did not acknowledge the fact that maternity has the highest number of patient complaints and adverse patient outcomes reports from hospital acquired infection and complications causing unwarranted harm on the basis of sex discrimination compared to other areas of health, including mens health. The World Health Organisation (WHO) advises that caesarean-section is the number 1 surgery in the world and the surgery itself is the number 1 medical error in the world. It is well known that young women are particularly influenced

and coerced into unwarranted intervention as well as verbal abuse based on their age in combination with their female sex, for their perceived ignorance, likelihood of compliance and reduced ability to complain when physically/emotionally harmed and caring for a newborn.

**Discussion question 9**

a. **Should the additional words "in the presence of a person" be added to the legal meaning of sexual harassment in the Act? What are the implications outside of a work setting?**

We support that additional words "in the presence of a person" be added to the legal meaning of sexual harassment in the Act.

b. **Should a further contravention of sex-based harassment be introduced? If so, should that apply to all areas of activity under the Act?**

We support that a further contravention of sex-based harassment be introduced and that it should apply to all areas of activity under the Act, specifically including the provision of reproductive health and maternity services.

c. **Should the Act explicitly prohibit creating an intimidating, hostile, humiliating or offensive environment on the basis of sex? If so, should that apply to all areas of activity under the Act?**

We agree that the Act should explicitly prohibit creating an intimidating, hostile, humiliating or offensive environment on the basis of sex. We support that this contravention apply to all areas of activity under the Act, specifically including the provision of reproductive health and maternity services.

d. **Proposal that QHRC considers including obstetric violence as an additional explicit contravention in the Act**

Sex-based harassment, which constitutes a form of sex discrimination, has recently been included as an explicit contravention in the federal Sex Discrimination Act. Sex-based harassment is defined as "any unwelcome conduct of a seriously demeaning nature by reason of the person's sex in circumstances in which a reasonable person would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated".[1]

We propose that QHRC considers the inclusion of another form of sex-based harassment, namely 'obstetric violence' as an additional, explicit contravention in the Act. Obstetric violence refers to non-consented, coercive and discriminatory treatment of childbearing women by health professionals during the provision of reproductive health and maternity services.[2] While a definition for obstetric violence has not yet been agreed within the global

[1] Australian Human Rights Commission. (2021). Complaints under the Sex Discrimination Act. Retrieved from https://humanrights.gov.au/complaints/complaint-guides/information-people-making-complaints/complaints-under-sex-discrimination-act

[2] Williams, C. R., Jerez, C., Klein, K., Correa, M., Belizán, J. M., & Cormick, G. (2018). Obstetric violence: A Latin American legal response to mistreatment during childbirth. *BJOG: An International Journal of Obstetrics & Gynaecology, 125*(10), 1208-1211. doi:10.1111/1471-0528.15270

research community, obstetric violence has been described as "negligent, reckless, omissive, discriminatory and disrespectful acts by health professionals and legitimised by the symbolic relations of power that naturalise and trivialise their occurrences".[3] As obstetric violence is a systemic problem that occurs at both structural/institutional and interpersonal levels, it is not confined to the behaviours of a specific profession. Although obstetric violence is a longstanding problem which is prevalent across both low to middle-income and high-income countries such as Australia, it has been recognised as a global problem relatively recently, within approximately the past ten years.[4]

**Evidence demonstrating why this contravention should be prohibited in the Act**
Mistreatment and violations of women's physical and psychological integrity during the provision of reproductive health and maternity services can have long-term consequences for women, families and communities. The World Health Organisation and various United Nations (UN) bodies have identified that the disrespectful and abusive treatment of women during facility-based childbirth can also sometimes constitute human rights violations.[5]

These international bodies have made multiple recommendations regarding the need for States to eliminate discrimination and violence against women that occurs during the provision of reproductive health and maternity services. For example, the Respectful Maternity Care Charter: The Universal Rights of Childbearing Women and Newborns was developed in 2011 (updated in 2019) to model and articulate the rights of women and newborns in the maternity services context, with the first element being the right to be free from harm and ill treatment.[6] This element aligns with the International Covenant on Civil and Political Rights 1966, Article 7, which states that no one shall be subjected to torture or to cruel, inhuman or degrading treatment and no one shall be subjected without their free consent to medical treatment or scientific experimentation.[7]

In 2015, a Joint Statement by UN Human Rights Experts noted that harmful stereotypes and multiple and intersectional forms of discrimination based on sex and gender contributes to violations of women's sexual and reproductive health rights. These experts urged States to address acts of obstetric and institutional violence experienced by women accessing

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[3] Jardim, D. M. B., & Modena, C. M. (2018). Obstetric violence in the daily routine of care and its characteristics. *Rev Lat Am Enfermagem, 26*, e3069. doi:10.1590/1518-8345.2450.3069

[4] Chadwick, R. (2021). Breaking the frame: Obstetric violence and epistemic rupture. *Agenda, 35*(3), 104-115. doi:10.1080/10130950.2021.1958554

[5] World Health Organisation. (2014). Prevention and elimination of disrespect and abuse during facility-based childbirth. https://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth-data/en/; Simonovic, D., UN Human Rights Council Special Rapporteur on Violence against Women, & UN Secretary General. (2019). *A human-rights based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*. New York, NY: United Nations https://digitallibrary.un.org/record/3823698?ln=en&fbclid=IwAR10CY66HCkNKxYLa3W_e3PNEksTWBcXA5z4kWr12s2nrDUFmyFEomXQwEo/

[6] Respectful Maternity Care Advisory Council and White Ribbon Alliance for Safe Motherhood (WRA). (2011). *Respectful Maternity Care: The universal rights of childbearing women and newborns*. https://www.whiteribbonalliance.org/rmcresources

[7] Australian Human Rights Commission. (2021). International Covenant on Civil and Political Rights – Human rights at your fingertips. https://humanrights.gov.au/our-work/commission-general/international-covenant-civil-and-political-rights-human-rights-your

reproductive health and maternity services in health facilities.[8] In 2016, the Report of the Working Group on the issues of discrimination against women in law and in practice expressed concerns about the overmedicalisation of birth and urged States to prevent the instrumentalisation of women's bodies during the birthing process. To prevent the abusive treatment of women during birth, the Working Group's recommendations included that States regulate birthing facilities to ensure respect for women's autonomy, privacy and dignity while ensuring that penalties for obstetric violence are incurred, particularly for forced or coerced medical treatment and for denial of pain relief to women.[9]

The UN Human Rights Council Special Rapporteur for Violence against Women (Special Rapporteur) presented a landmark report to the UN General Assembly in 2019, identifying the structural causes underpinning the mistreatment of women by reproductive health services, with a focus on childbirth and obstetric violence.[10] The UN Special Rapporteur reported that the mistreatment of childbearing women by reproductive healthcare services during childbirth in health facilities globally is "widespread and ingrained in the health system". Structural causes included discriminatory laws and practices, harmful stereotypes, health system conditions and constraints, power dynamics and abuse of the doctrine of medical necessity. The UN Special Rapporteur's recommendations included that States conduct independent investigations into women's allegations of mistreatment in health facilities with the view to revising laws, national policies and reproductive health plans.

In 2020, the UN's Committee on the Elimination of Discrimination against Women (CEDAW) made its first decision regarding obstetric violence in relation to a complaint brought by a Spanish mother concerning her mistreatment by health professionals during labour and birth at a Spanish public hospital.[11] Following the CEDAW Committee's decision and recommendations, the Spanish government announced in 2021 that it would include 'obstetric violence' in its legislation as an additional type of violence against women.[12]

Evidence that childbearing women are subjected to discriminatory, coercive and non-consented treatment while accessing reproductive health and maternity services in Queensland and in other Australian jurisdictions has been demonstrated in several research

[8]Joint statement by United Nations experts in the field of human rights on the 2030 Agenda for Sustainable Development https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16490&LangID=E/

[9] Report of the Working Group on the issue of discrimination against women in law and in practice. A/HR/32/44, paras. 74 and 106. https://undocs.org/en/A/HRC/32/44

[10] Simonovic, D., UN Human Rights Council Special Rapporteur on Violence against Women, & UN Secretary General. (2019). *A human-rights based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*. New York, NY: United Nations Retrieved from https://digitallibrary.un.org/record/3823698?ln=en&fbclid=IwAR10CY66HCkNKxYLa3W_e3PNEksTWBcXA5z4kWr12s2nrDUFmyFEomXQwEo/

[11] UN Committee on the Elimination of Discrimination Against Women. (2020). *Decision adopted by the Committee, concerning communication No.138/2018*. https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/75/D/138/2018&Lang=en

[12] Borraz, M., & Aeqena Aguilar, A. (2021, 27 June). Towards Equality: In Spain, a network of activists, lawyers and midwives break the silence on obstetric violence, Online. *SparkNews*. https://www.sparknews.com/towards-equality/spain-network-of-activists-obstetric-violence/

studies and reports.[13] Independent, state-based reviews have also reported discriminatory, coercive and non-consented treatment of women while accessing reproductive health and maternity services. For example, in its 2020 Parliamentary inquiry into maternity services, the Australian Capital Territory (ACT) Parliamentary Committee reported that power imbalances within maternity services lead to structural and interpersonal discrimination against pregnant women and mothers.[14] The 2018 Victorian Parliamentary Inquiry into Perinatal Services also reported that birthing women had medical procedures performed on them without their consent and recommended a state-wide review with regard to childbearing women's human rights.[15] Submissions prepared by Human Rights in Childbirth in 2019 and by Maternity Choices Australia in 2020 also document evidence of discrimination and violence against women while accessing maternity services in Queensland and other Australian jurisdictions.[16]

Queensland Health published the "Partnering with the woman who declines recommended maternity care" guideline in 2020[17], partially in response to research finding that childbearing women in Queensland are subjected to coercive and non-consented treatment by health professionals during the provision of publicly funded maternity services.[18] While establishing this guideline appears to be a useful step towards acknowledging a significant cultural problem within Queensland's public maternity services, there is currently no proposed implementation plan or funding for distribution of this guideline to

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[13] Dahlen, H., Kumar-Hazard, B., & Schmied, V. (Eds.). (2020). *Birthing outside the system: The canary in the coal mine*. Abingdon, Oxon: Routledge. Keedle, H., Schmied, V., Burns, E., & Dahlen, H. G. (2022). From coercion to respectful care: Women's interactions with health care providers when planning a VBAC. *BMC Pregnancy Childbirth, 22*(1). doi:10.1186/s12884-022-04407-6. Maternal Health Matters. (2021). *The Mother's Tale: Women's Experiences of Maternity Care in Australia. The Birth Dignity Survey 2020*. Retrieved from https://maternalhealthmatters.org.au/submissions-and-reports/. Michaels, P. A., Sutton, E., & Highet, N. (2019). Violence and trauma in Australian birth. In C. Pascoe Leahy & P. Bueskens (Eds.), *Australian mothering: Historical and sociological perspectives* (pp. 239-255). Switzerland: Palgrave Macmillan.

[14] Australian Capital Territory Legislative Assembly. (2020). *Report on inquiry into maternity services in the ACT*. (10). https://www.parliament.act.gov.au/parliamentary-business/in-committees/previous-assemblies/standing-committees-ninth-assembly/standing-committee-on-health,-ageing-and-community-services/Inquiry-into-the-Maternity-Services-in-the-ACT#tab1251198-5id

[15] Parliament of Victoria. (2018). *Inquiry into perinatal services: Final report*.https://www.parliament.vic.gov.au/fcdc/inquiries/article/2822:

[16] Human Rights in Childbirth. (2019). *Submission to the Australian Human Rights Commission for its "Free and Equal: An Australian conversation on human rights" process* Retrieved from Sydney, Australia: https://humanrights.gov.au/sites/default/files/2020-09/sub_149_-_human_rights_in_childbirth.pdf. Maternity Choices Australia. (2020). *Application of the Human Rights Act of Queensland to the provision of public maternity services in Queensland: Policy brief for the Queensland Human Rights Commission*. https://www.maternitychoices.org/qldadvocacy

[17] Clinical Excellence Queensland. (2020). Guideline: Partnering with the woman who declines recommended maternity care, V1.0. https://www.health.qld.gov.au/consent/html/pwdrmc/

[18] Jenkinson, B., Kruske, S., & Kildea, S. (2017). The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis. *Midwifery, 52*, 1-10. doi:10.1016/j.midw.2017.05.006. Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy Childbirth, 17*(21). doi:10.1186/s12884-016-1197-0. State of Queensland (Queensland Health). (2019). *Rural maternity taskforce report*. Retrieved from https://clinicalexcellence.qld.gov.au/priority-areas/patient-experience/maternity-service-improvement/rural-maternity: https://clinicalexcellence.qld.gov.au/priority-areas/patient-experience/rural-maternity-taskforce/rural-maternity-taskforce-report

childbearing women across Queensland and the guideline does not yet include information about making a complaint to QHRC.

Childbearing women in Queensland continue to disclose their experiences of discriminatory, coercive and non-consented treatment to MCA and other community advocacy organisations. MCA has liaised with Queensland Health regarding women's allegations of human rights violations, however at this stage there appears limited further action taken by the Queensland government at a state-wide level to address this form of sex-based discrimination and violence against women. For example, the Queensland Health Minister in late 2021 advised MCA that although Queensland Health is committed to a culture that respects human rights as central to its service provision, MCA volunteers were encouraged instead to refer women's concerns about their mistreatment to individual Hospital and Health Services.

**How is Obstetric Violence defined in other countries' legislation?**
While several Latin American countries have passed legislation within the past 15 years that prohibits obstetric violence, these countries have taken slightly different approaches to defining obstetric violence.[19] For example, the Venezuelan government passed legislation in 2007, defining obstetric violence as "appropriation of women's bodies and reproductive processes by health professionals, expressed as dehumanising treatment and/or abusive medicalisation and pathologisation of natural processes, resulting in loss of autonomy and the capacity to decide freely about their own bodies and sexuality, negatively impacting women's quality of life".[20] Specific examples of actions that constitute obstetric violence include intervening to accelerate labour without a woman's express voluntary informed consent and performing a non-medically indicated caesarean section without the woman's express voluntary informed consent. Argentina legislated broader protections by guaranteeing a woman's right to a birth companion which improves clinical outcomes, while also imposing sanctions for obstetric violence which is defined as "exercised by health personnel over a woman's body and reproductive processes, expressed as dehumanising treatment, and/or abusive over-medicalisation of the natural processes".[21]

In comparison, the Plurinational State of Bolivia's legislation, which does not explicitly refer to obstetric violence, referenced violence within health services and 'violence against reproductive rights', which is defined as "acts or omissions that impede, limit and otherwise violate women's right to information, orientation, comprehensive care and treatment during pregnancy and miscarriage, labour, birth, postpartum period and breastfeeding." [22]

**How would inclusion of obstetric violence as a form of prohibited sex-based discrimination promote the rights to equality and non-discrimination?**
Explicit inclusion of obstetric violence as a contravention in the Act would contribute to clarifying the types of behaviours that constitute unacceptable treatment of women in the

[19] Williams, C. R., Jerez, C., Klein, K., Correa, M., Belizán, J. M., & Cormick, G. (2018). Obstetric violence: A Latin American legal response to mistreatment during childbirth. *BJOG: An International Journal of Obstetrics & Gynaecology, 125*(10), 1208-1211. doi:10.1111/1471-0528.15270
[20] Williams et al. (2018). p 1209.
[21] Williams et al. (2018). p 1209.
[22] Williams et al. (2018). p 1209.

provision of reproductive health and maternity services. Despite compelling evidence demonstrating the mistreatment of childbearing women within the maternity services context in Queensland and within other Australian jurisdictions over several years, state, territory and federal Australian governments appear reluctant to acknowledge and directly address this type of sex-based discrimination and violence against women.[23] Explicit inclusion of obstetric violence as a prohibited form of sex-based discrimination in the Act would potentially encourage the Queensland government and other entities that provide reproductive health and maternity services to take proactive and preventative actions to address and eliminate this form of sex-based discrimination and violence against childbearing women and mothers.

**Discussion question 10**
**Should the Act include a direct right of access to tribunals?**
We support the inclusion of a direct right of access to tribunals. Mothers have advised MCA that they would not proceed with a complaint due to the additional and lengthy steps involved in accessing the tribunal.

**Discussion question 14**
**Is 1 year the appropriate timeframe within which to lodge a complaint? Should it be increased, and if so, for how long?**
We support an extension to the time limit, to at least 2 years. The physiological recovery from birth requires at least 2 years according to Dr Oscar Serallach, not withstanding women who have sustained diagnoses (disability) as a result of their experiences. Mothering is largely unpaid so consumers bear the cost of childcare to make a complaint and may be less efficient when stopping to have breastfeeding breaks, than complainants without young dependant children. Maternity consumer advocacy is unfunded, again slowing the peer-to-peer support process. There are no specialist community legal centres for obstetric violence adding another barrier to efficiency and access.

**Discussion question 16**
**Should a representative body or a trade union be able to make a complaint on behalf of an affected person about discrimination? Why or why not?**
We support that a representative body or a trade union should be able to make a complaint on behalf of an affected person about discrimination. Women have advised MCA they would give us authority to handle their complaint to reduce the risk of being re-traumatised and due to cost/time/disability/carer responsibilities as outlined in Q14.

**Should representative complaints be confined to the conciliation process or should they be able to proceed to the tribunal?**
We support that representative complaints should be able to proceed to the tribunal.

**Discussion question 21**
**Do you support the introduction of a positive duty in the Anti-Discrimination Act?**

[23] Dahlen, H., Kumar-Hazard, B., & Schmied, V. (Eds.). (2020). *Birthing outside the system: The canary in the coal mine*. Abingdon, Oxon: Routledge.

**Should a positive duty cover all forms of prohibited conduct including discrimination, sexual harassment and victimisation?**
**Should a positive duty apply to all areas of activity in which the Act operates, or be confined to certain areas, such as employment?**
**Should a positive duty apply to all entities that currently hold obligations under the Anti-Discrimination Act?**
We support the introduction of a positive duty that would cover all forms of prohibited conduct and applies to all areas of activity, specifically including the provision of reproductive health and maternity services. We support the positive duty applying to all entities that currently hold obligations under the Act. Community advocacy organisations have invested significant effort over several years to protect women from discrimination and violence when they access reproductive health and maternity services. We consider that introducing a positive duty on entities that provide reproductive health and maternity services would contribute to strengthening protections for childbearing women.

**Discussion question 35 – While retaining sex as an attribute, should an additional attribute of gender be introduced? If so, should it be defined and how?**
MCA is pleased that sex will be retained as a protected attribute.

**Discussion question 52 – Should the definition of goods and services that excludes non-profit goods and service providers be retained or change? Should any goods and services providers be exempt from discrimination, and if so, what should the appropriate threshold be?**
Not for profit health care providers in Queensland should be included in the Act as consumers are referred to these hospitals based on their catchment and have limited options to access other services. There is growing use of public private partnerships in Queensland which have poorer outcomes for women as per NSW Northern Beaches Parliamentary Inquiry. These women need additional sexual and reproductive health protections as these private hospitals are often run by religious organisations [redacted] which do not perform sterilisation by maternal request as part of their childbirth services.