National Advocates for Pregnant Women

N A P W

NAPW Working Paper: Birth Justice as Reproductive Justice
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Introduction

Reproductive justice provides a comprehensive vision. As beautifully articulated by Forward Together, this kind of justice "will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives."[2]

We note though, that despite a vision that encompasses all women and girls as well as all aspects of women's lives and health, the issues of pregnancy, labor, and childbirth receive relatively little attention when compared to other issues.[3] For example, while the word "birth" appears seven times in Forward Together's defining document, only one of these relates at all to the delivery of a child. The word birth appears once in the definition of reproduction,[4] five times in reference to "birth *control*" and once in reference to "birth *defects*." "Childbirth" is not mentioned at all. The word "labor" appears numerous times—but in the broader context of work, not childbirth—and the word "delivery" appears once in terms of "*service* delivery." And though it is clear that Forward Together's action recommendations are not meant to be exhaustive, none of the actions in the "What You Can Do" section of the statement relate to the conditions under which American women experience labor and childbirth. Since more than 80% of women have become pregnant and given birth by the age of 40, we believe this area of the reproductive justice deserves further thought and development.

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[1] We also acknowledge the significant contribution of Angela Moreno in the development of this paper

[2] See Forward Together's 2005 *A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights, and Reproductive Justice*

[3] We acknowledge that SisterSong member organizations include the International Center for Traditional Childbearing (ICTC) and SisterSong's paper *Understanding Reproductive Justice* explains that the Reproductive Justice model, "offers a new perspective on reproductive issue advocacy, pointing out that as Indigenous women and women of color it is important to fight equally for (1) the right to have a child; (2) the right not to have a child; and (3) the right to parent the children we have, as well as to control our birthing options, such as midwifery." http://www.sistersong.net/publications_and_articles/Understanding_RJ.pdf

[4] "Reproduction encompasses both the biological and social processes related to conception, birth, nurturing and raising of children as participants in society."

Today a vibrant and growing movement of activists, many not even familiar with reproductive justice, are working on issues relating to the circumstances under which women experience labor and childbirth. NAPW seeks to ensure that "birth justice" is fully incorporated into the reproductive justice movement. *This occurs when the goals of reproductive justice fully address and incorporate not only women's ability to make decisions about whether and when to have children, but also about how they are treated during the critical times of labor and childbirth.*

By addressing women's needs at all stages of all their reproductive lives, we can ensure that reproductive justice is not simply a repackaging of other models of advocacy that have ignored the needs of marginalized women and challenge the idea that reproductive justice is simply "pro-abortion."

NAPW's strategy for achieving reproductive justice includes the recognition that those who work for birthing rights, and those who work for what has been known as "reproductive rights" are all working on behalf of the same women who are threatened by the same laws and social, economic and political structures:

- **We are advocating for the same women.** 61% of women who have abortions have already given birth; By the age of 40, 84 % of women have become pregnant and given birth
- **We are all hurt by a single-issue focus on abortion that distracts attention from shared values and needs for health care reform, safe communities and economic security.**
- **We stand on the same legal ground.** While we may have very different personal priorities and moral perspectives, such as differences about abortion or differences in priorities regarding home and work life, we must share a *legal and political* vision that ensures that at no point during pregnancy does a woman lose her civil, constitutional, and human rights. A paradigm that separates the fetus from the pregnant woman for the purposes of establishing personhood necessarily deprives a pregnant woman of her human rights and personhood. This not only affects her ability to terminate a pregnancy or use certain types of birth control, it affects her ability to make choices about her own healthcare and the circumstances under which she gives birth. State interests in the unborn provide the legal arguments for both denying women the right to end a pregnancy, for arresting her for murder if she suffers a stillbirth that resulted from her decision to delay cesarean surgery, and for taking her into custody and forcing her to undergo surgery for the benefit of the "unborn" child. *See NAPW's video:* "How Personhood USA & The Bills They Support Will Hurt ALL Pregnant Women"[5]

What is "Birth Justice"?

One straightforward example of birth justice is ensuring that pregnant women in prison are not forced to experience pregnancy, labor, or childbirth in shackles. But it is much more than being free from the physical restraints of shackles or court-ordered surgeries. It is, at minimum,

[5] *Available at* http://www.youtube.com/watch?v=-3X4_p3yAC8

having access to evidence-based maternity care, accurate information about pregnancy, the risks and benefits of medical procedures, and the agency to choose whether or not to undergo those medical procedures. It is having the power to make those choices and give birth free from fear of intimidation or interference from outsiders to "noncompliance" with medical advice, or because of poverty, race or ethnicity, or immigrant status. It is also having access to culturally respectful labor support.

Birth justice is ensuring that no aspect of pregnant women's decision making is minimized or belittled. For example, the September 11, 2009 segment on NBC's "Today Show"[6] originally titled "The Perils of Midwifery" depict choice in the location of birth as an issue of privilege. Portraying women's childbirth choices as "hedonistic," "like a spa treatment," and based on what celebrities are doing closely parallels the divisive rhetoric used by the anti-choice activists who portray women as superficial, self-indulgent, and only interested in their own convenience. Birth justice, whether or not you or your organization take a position on any particular birth choice, requires supporting a woman's right to autonomous decision-making, recognizing her ability to assess the risks on behalf of herself and her family, and respecting her dignity no matter what choice she makes and regardless of the outcome.

Birth justice, like all other aspects of reproductive justice is an intersectional issue, as these examples make clear:

- Increasingly, Asian-American women pregnant with babies fathered by Caucasian men are being told that they are unlikely to be able to give birth vaginally because their pelvises are too small[7] to accommodate Caucasian babies.[8]
- A New Jersey woman went to a hospital to deliver her baby, and was asked to preauthorize all possible medical interventions, including cesarean surgery, upon admission. She exercised her right to informed refusal, authorizing most interventions but stating that she would authorize the surgery only when it became medically necessary. Unhappy with her answer and unsure whether a pregnant woman has a right to decline medical treatment, physicians asked two psychiatrists to evaluate her. The first declared her competent to make her own medical decisions, while the second's interview was cut short by the spontaneous vaginal delivery of a perfectly healthy baby girl. Nonetheless, the hospital reported her to child welfare authorities for committing "medical neglect" against an "unborn child." The state removed the newborn from her custody, eventually terminating her parental rights. The hospital at which she delivered currently has a cesarean rate of nearly 50%.
- Many hospitals discourage or disallow certain practices that have deep cultural meaning, e.g. laboring in certain positions, disposal of the placenta, use of medical interventions, presence of men or labor support at the delivery
- A Minnesota woman reported that in talking to a nurse about her delivery (during which she was very distraught due to having repeatedly been given rough vaginal examinations while

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[6] *Available at* http://today.msnbc.msn.com/id/26184891/vp/32795933#32795933

[7] Incidentally, this condition is referred to as "inadequate pelvis." The terms for this and other obstetrical complications ("incompetent cervix," "dysfunctional labor," "failure to progress") reflect/reinforce a standing negative view of pregnant women as somehow deficient

[8] *See, e.g.,* Michael J. Nystrom et al., *Perinatal Outcome Among Asian-White Interracial Couples*, 199 AM. J. OBSTETRICS & GYNECOLOGY 385.e1 (2008).

she pleaded with the nurse to "stop" and "get out") the nurse informed her that the way that she labored "was not in the normal range," that she couldn't understand this because the laboring woman was "educated," and that her reaction to labor "reminded her of Somali women who had their genitals mutilated in their home countries."
- The only comprehensive study of court-ordered cesareans found that 80% of women subjected to court-ordered cesarean surgery were women of color, and 24% of these cesareans were ordered on women for whom English was not their first language.
- A recent study by Kaiser Permanente showed that African-American women had the highest rate of primary cesarean, and that this rate *was not attributable to other factors such as education, prenatal care, or smoking during pregnancy*. The researchers concluded that "mother's race might have a bearing on cesarean section outcome," but from a critical perspective this raises the question of whether *practitioner biases* may in fact be the determinative factor.
- In one study, doctors reported having practiced more "defensive medicine," which can lead to unnecessary and possibly risky medical interventions, on low-income patients. This was based on a perception—not supported by any evidence—that low-income patients are more litigious.

It is therefore imperative that marginalized women have not just a proverbial seat at the table, but significant input in the birth justice agenda.

Shaping Agendas, Reframing Debates and Creating a True Culture of Life

In 1993, Pope John Paul II urged Americans to "spread a culture of life." All too often, however, this has meant privileging the state's interest in protecting fetal life over the autonomy, health, or even the lives of pregnant women. Reproductive justice advocates understand that a *true* culture of life also values the women who give that life, and must ensure that when advocating on issues of reproductive justice, we look at all points of a woman's reproductive life and consider the ways in which these issues affect birthing women.

- **Truly comprehensive sex education includes information about pregnancy and childbirth.** Sex education can empower young women to make healthy choices about their sexuality. By the same token, education about pregnancy, different models of prenatal care, and the risks and benefits of medical procedures *before women become pregnant* can empower them to make healthy choices about their pregnancies and ensure that informed consent is a process that begins long before a woman is in labor.
- **Access to reproductive healthcare includes access to healthy, full-term deliveries, appropriate, evidence-based maternity care, vaginal birth after cesarean surgery, and out-of-hospital birth options** *as well as* abortion, contraception, and STI treatment**.** Many reproductive justice advocates know that 85% of U.S. counties have no abortion providers – but do not know that at least that many also lack facilities that will attend women delivering vaginally after a cesarean, birthing centers, or providers trained to perform vaginal breech deliveries. And while so many county have none of these, many of the same counties have "crisis pregnancy centers" that do not advance any aspect of women's reproductive health or rights.
- **Women need accurate, non-coercive informed consent for *all* medical procedures**

related to their reproductive health. Regulations designed to make it harder for women to access abortion services have been passed in the guise of "informed consent" laws and are based on unsupported claims that women are not fully informed or are being coerced into terminating wanted pregnancies. However, there is little attention to the point in pregnancy where evidence suggests that women are in fact being denied informed consent: during labor and childbirth. The *Listening to Mothers I & II* surveys showed that significant numbers of women felt rushed or even coerced into medical interventions like induction, episiotomy, or cesarean surgery during their births, and many were unable to answer basic questions about the side effects and risks of interventions like pitocin induction, epidural anesthesia, or even cesarean surgery. See *Concerned About Coerced Abortions? Try Saying No to Cesarean Surgery*[9] While the World Health Organization has estimated that there is no medical justification for a cesarean rate of over 10-15%, and has found that higher rates do more harm than good, the 2007 U.S. cesarean rate was 31.8%, more than twice the optimal level. This raises serious the questions of whether non-medical factors such as financial interests or physician convenience may be responsible for the excess, and whether women are being given the information that they need in order to be active decision-makers in the process.[10]

- **Birthing issues require the same critical/intersectional analysis as other aspects of reproductive justice.** Reproductive justice advocates must be vigilant of the same stereotypes that are applied to women in other contexts when talking about maternity care and childbirth. As many are aware, the U.S.'s high infant and maternal mortality relative to other industrialized nations is not borne equally across racial lines, with African American mothers and babies vastly disproportionately affected regardless of maternal education or socioeconomic status. However, rather than addressing the consequences of lifelong inequalities in access to health care, income, and nutrition, explanations often spuriously point to "lifestyle choices," for example assuming drug use among African American women and further assuming that drug use would cause the poor outcomes. This claim is made despite lack of supporting research and despite the fact that overall rates of use of illegal drugs are the same across race lines and only 3-4% of pregnant women use any illegal drug. This leads to a form of racial profiling in maternity care, whereby women of color are automatically written off as "high risk" and treated with the most aggressive, medically-interventionist care possible. However, there has been no improvement in maternal or fetal outcomes from a technocratic model of maternity care focused solely on the worst-case scenario rather than the holistic individual needs of the pregnant woman. While 9 months of prenatal care cannot correct lifetimes of healthcare disparities or the direct and indirect impacts of racism on the body, holistic prenatal care can help improve birth outcomes for communities of color. In fact, evidence suggests that respectful, woman-focused care that makes women active participants in their own care can close race disparities in low-birthweight infants. Such a model, The JJ Way, developed by midwife Jennie Joseph, was proven effective in a study of outcomes of Ms.

[9] http://www.huffingtonpost.com/lynn-m-paltrow/concerned-about-coerced-a_b_190237.html
[10] Carol Sakala & Maureen P. Corry, Evidence-Based Maternity Care: What It Is and What It Can Achieve (2008).

Joseph's Winter Park, FL birth center "The Birth Place."[11]

- **The judgmental rhetoric applied to women who choose to abort is applied to women who carry to term.** Reproductive justice advocates should be aware of the climate surrounding pregnancy. Our society scrutinizes and judges every aspect of a woman's pregnancy, from her decision to terminate, her "fitness" to parent a child she wants to carries to term, her choice to work or not work, and even the foods she eats, regardless of whether she actually has any control over these circumstances of her pregnancy. It is with this understanding that we approach birth justice. We question the overuse of unnecessary medical interventions, oppose any form of coercive medical treatment, and demand access to midwifery care, VBAC, and out-of-hospital birth options, but respect and honor women's choices regarding their prenatal care and birth. No matter how, where, or with whom a woman chooses to give birth, she deserves: to receive appropriate and respectful care, to be fully informed of the risks and benefits of every procedure in a way that she can understand without the use of pressure or scare tactics, and to refuse any procedure.
- ***All* women's reproductive experiences deserve validation.** Despite claims by anti-choice groups, and even Supreme Court Justices, that abortions are necessarily traumatic and lead to so-called "post abortion syndrome" reproductive justice advocates understand that women's emotional experiences surrounding their choices are nuanced and varied. Some women make the decision to end a pregnancy with relief and without hesitation, while others may feel ambivalent or even regretful, or may be at peace with the decision but traumatized by how the procedure was performed, and *all* of them deserve emotional space and support. In the same way, women's experiences of childbirth may run the gamut from euphoric to terrifying, regardless of the birth outcome. However, our society leaves almost no space for women to have feelings for their birth other than joy and gratitude for a healthy baby. While there has been significant research into Post-Partum Depression, much less attention and support is given to the emotional impact of either the physical experience of childbirth or a woman's perception of how she is treated during labor. This is the case despite a growing body of evidence and self-report suggesting that significant numbers of women experience some or all of the clinical symptoms of Post-Traumatic Stress Disorder after births in which they experience extreme fear, loss of agency/control, or mistreatment by medical personnel.[12] Furthermore, the lack of screening for PTSD risk factors and symptoms, and the stigma surrounding expressing negative feelings about a birth has meant that birth trauma has gone unnoticed and untreated. Reproductive justice advocates can promote birth justice by expanding the

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[11] COMMONSENSE CHILDBIRTH, INC., PROGRAM EVALUATION (2008) *Available at* http://www.jenniejoseph.com/sites/jenniejoseph.com/files/Commonsense%20Childbirth%20Evaluation%20HCECF.doc

[12] Cheryl Tatano Beck, *Post-Traumatic Stress Due to Childbirth: the Aftermath*, 53 NURSING RES. 216 at 223-224 (July/Aug 2004) (noting that a comprehensive review of studies shows the incidence of clinical Post-Traumatic Stress after childbirth may be as high as 6%); NICETTE JUKELEVICS, UNDERSTANDING THE DANGERS OF CESAREAN BIRTH: MAKING INFORMED DECISIONS 62-63 (2008)(noting that how a woman is treated by healthcare personnel or perceives her experience during birth can bear upon the trauma, causing shame, humiliation, or stigma and strain mother-infant bonding).

optimal birth outcome of "healthy mother, healthy baby" to include women's *mental* health needs as well.

Increasing Activism, Coverage, and Momentum

NAPW believes that legal scholarship can be effective in bringing about social change. For example, the feminist legal community helped to bring issues like sexual harassment and domestic violence into the lexicon of gender equality. Moreover, courts often rely on influential law review articles when addressing new and difficult issues. A seminal article by Cyril Means[13] about abortion rights not only helped encourage academic discussion about an issue that was once unspeakable, it also helped shape the law when it was cited by the Supreme Court in *Roe v. Wade*.[14] In the case of Angela Carder's forced caesarean, the D.C. court relied specifically on Janet Gallagher's[15] groundbreaking article in the field when it recognized the procedural shortcomings inherent in emergency court hearings called to weigh maternal vs. state-cum-fetal rights.[16] More recently, Sylvia Law's article on insurance coverage for contraception[17] was cited in *Erickson v. Bartell Drug Co*.,[18] in which a federal court in Washington State held that a company discriminated against its employees on the basis of sex by excluding contraception from its employee insurance policies.

Cases such as these highlight the importance of fostering legal scholarship on birth justice to act as a catalyst for the legal community to address issues that NAPW and our allies consider crucial to a full understanding of Reproductive Justice. To this end, NAPW has developed its law school writing competitions to leverage the enthusiasm and creativity of emerging feminist legal scholars and spark critical thinking about the need to address childbirth and birthing rights as constitutional and human rights issues.

The first contest asked law students to posit civil and human rights challenges to hospital policies banning women from delivering vaginally after cesarean section. All of the top three finalists have had their entries accepted for publication in law reviews and journals, where they will not only advance the discourse, but will be available to practitioners researching possible challenges. Furthermore, the contest has inspired birth activists to propose legislation specifically protecting the rights informed consent and refusal for pregnant women.

The following year, students were asked to address the absence of birthing rights issues in feminist jurisprudence courses in law school. Our hope is that by highlighting the absence,

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[13] Cyril Means, *The Phoenix of Abortional Freedom: Is a Penumbral or Ninth-Amendment Right About to Arise from the Nineteenth-Century Legislative Ashes of a Fourteenth-Century Common-Law Liberty?,* 17 N.Y.L.F. 335 (1971).
[14] Roe v. Wade, 410 U.S. 113 (1973).
[15] Janet Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9 (1987).
[16] *In re* A.C., 573 A.2d 1235, 1248 (D.C. 1990) (en banc).
[17] Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 364-68 (1998).
[18] Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266 (2001).

students can encourage professors of feminist jurisprudence to teach about, and write texts that include, issues of childbirth including midwifery.

In addition to academic activism, birth justice is an area of reproductive justice in which grassroots activism has been immensely successful. Organizations like the Big Push for Midwives and Citizens for Midwifery have protected and promoted the legal status of midwives and out-of-hospital birth options. Others, like Choices in Childbirth, have successfully proposed legislation that requires hospitals to provide information about their obstetrical practices, including cesarean section and episiotomy. Still others, like the International Cesarean Awareness Network and Solace for Mothers have provided support for birthing women and brought attention to issues that have long gone unnoticed, including birth trauma and the dwindling number of hospitals that attend women desiring VBAC.

Furthermore, the ongoing healthcare debate has provided an unprecedented opportunity to link issues affecting pregnant and birthing women to access to healthcare broadly. For example, in 2008, the New York Times ran a story[19] about Peggy Robertson, a California mother who was told by Golden Rule Insurance that she was uninsurable due to a pre-existing condition: a prior cesarean section. They were, however, happy to insure her if she underwent sterilization. Apart from the Times article, the story was not widely publicized at the time. However, Mrs. Robertson, along with the advocacy director of the International Cesarean Awareness Network, recently testified before the Senate about this issue as gender disparity in access to health coverage. This story was picked up and recently ran on ABC's World News Tonight.[20]

Joy Szabo, an Arizona mother of four was forced to drive 350 miles to Phoenix to deliver her baby vaginally, even though she had had a prior VBAC (making her an excellent candidate for VBAC under ACOG guidelines), because the hospital changed its policy on VBAC since her third birth. When she asked what would happen if she came to the hospital in labor, the hospital CEO told her that the hospital would get a court order. The good news is that this story has drawn an unprecedented amount of attention—including CNN coverage[21]—to the fact that nearly half of U.S. hospitals will not attend vaginal deliveries for women with a prior cesarean. The bad news is that, even in the feminist blogosphere, many people seem to be unable to connect injustice of women having to travel hundreds of miles to avoid forced pregnancy to the injustice of having to travel hundreds of miles to avoid forced surgery, unable to see that a market-based solution (i.e. just find another hospital) excludes many or even most women, or unable/unwilling to conceptualize unwanted surgery as a violation of bodily integrity that women can experience as traumatic.[22]

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[19] Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, N.Y. TIMES, June 1, 2008, http://www.nytimes.com/2008/06/01/health/01insure.html

[20] ABC News, Do Insurers Discriminate Against Women? October 15, 2009, http://abcnews.go.com/video/playerIndex?id=8840437

[21] Elizabeth Cohen, *Mom Won't be Forced to Have C-Section,* Oct. 15, 2009, http://www.cnn.com/2009/HEALTH/10/15/hospitals.ban.vbacs/index.html

[22] Rachael Larimore, *Childbirth Is Not Burger King. You Can't Always Have It Your Way,* Oct. 19, 2009, http://www.doublex.com/blog/xxfactor/childbirth-not-burger-king-you-can%E2%80%99t-always-have-it-your-way

This is an opportunity for reproductive justice advocates to join their voices with birthing rights advocates and:

- reiterate the reproductive justice message that women should be the final decision-makers for what happens to their own bodies, and should be trusted that they are making these decisions based on the needs of their family and the information available to them, and not convenience, selfishness, or media fads, as rhetoric suggests.
- bring the reproductive justice movement's intersectional analysis to birthing activism by have conversations with birth activist organizations about the role that privilege plays in having a healthy birth free from coercion.
- connect the work of organizations like Exhale, that give women voice and space to express relief, regret, or even grief over their abortions to organizations like Solace for Mothers and Backline that give women space to feel ambivalent or even outraged about their experiences of pregnancy and childbirth.

Strategies for Change

- **Expanding the timeline.** As mentioned above, always ask what effect a proposal will have on all aspects of women's reproductive lives. For example a close look at a proposed Kansas "Unborn Victims of Violence Act" not only revealed how it was setting the stage for outlawing abortion, and was likely to punish women who went to term in spite of a drug problem, it also made midwives—but not doctors—vulnerable to criminal prosecution for a poor birth outcome.

- **Broadening the base.** Reach out to midwives and other birth professionals and activists as potential allies in ensuring women's autonomy and dignity. NAPW's National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women and other coalition-building endeavors have shown that cross-movement collaboration and communication over the "pro-life"/"pro-choice" gap are not only possible, but necessary.

- **Direct action.**
    - NJ NOW has launched the "Worst to First" campaign, which has succeeded in getting hospitals to commit to lowering their rates of primary cesarean section and episiotomy by holding demonstrations outside of hospitals. A similar campaign was recently launched in Connecticut.
    - Activists in the Bay Area have forestalled unnecessary child protective intervention by calling the agency and identifying Ob/Gyns who habitually call CPS to report women for their childbirth choices, and pointing out that they are abusing CPS as a source of coercive leverage against "noncompliant" patients.

- **Legislative Advocacy.**
    - Currently only two states have Maternity Information Acts, laws requiring reporting of rates of medical intervention during childbirth, and these exist only because of grassroots efforts mentioned above. When lawmakers suggest measures that would require abortion providers to publicize information about how many abortions they perform/what stage of pregnancy/what methods they use, demand that they prove

their supposed commitment to informed consent by mandating reporting of rates of instrumental birth, episiotomy, vaginal breech deliveries, and other childbirth interventions.
    - Organizations dedicated to improving birth outcomes and maternity care by promoting midwifery are pushing for (1) national health care reform that provides incentive for using of evidence-based practices rather than fee for service, which promotes more procedures regardless of efficacy; (2) equitable reimbursement and Medicaid reimbursement for midwives and out of hospital birth options; and (3) state licensing of Certified Professional Midwives

- **Litigation Efforts.** Because the focus of reproductive rights litigation has been on the right to prevent or end a pregnancy, legal theories and litigation to advance the rights of women in labor and giving birth, both in the form of affirmative challenges and legal defenses, are in their infancy.
    - On behalf of 20 allied organizations and experts in maternal/fetal health, NAPW filed an *amicus curiae*, or friend of the court, brief challenging a New Jersey family court's finding of medical neglect of an unborn child in *New Jersey Division of Youth and Family Services v. V.M and B.G.*, based on the mother's refusal to preauthorize cesarean surgery before it was medically necessary. NAPW and allies argued that New Jersey's abuse and neglect laws were not intended to apply to a woman's medical decision-making during pregnancy or birth, and that to rule that they do would compromise both informed consent and maternal/fetal health.
    - In July 2010, an Illinois woman was separated from her newborn for weeks and charged with medical neglect after having a precipitous breech birth at home. Her baby was born with a minor birth injury, which was undetectable to her midwives and to emergency room personnel. Nevertheless, because the family did not treat the birth as an emergency situation and present to the hospital immediately, for over six months they were subjected to invasive, humiliating, and unnecessary intervention by the state child welfare authority, and were allowed only limited contact with their baby. NAPW assisted the family's counsel with model motions that helped clarify for the court that birthing decisions are improper grounds for child welfare investigations, and the case was dropped in part. As of this writing, the case is still in litigation attempting to clear the family from the registry of child welfare offenders.
    - In March 2012, NAPW, along with several allies from the ACLU and National Birth Policy Alliance, helped a woman in South Carolina who was being threatened with abandonment or coerced surgery by her obstetrician because she wanted to give birth vaginally after cesarean section. NAPW and allies drafted a letter outlining the woman's legal rights and the ethical obligations of medical providers to respect her medical decision making. This letter has helped numerous other women across the nation.

- **Documentation Campaigns.** NAPW is currently piloting a campaign to document human rights abuses during childbirth. Like other violations that affect women disproportionately, such as domestic violence or date rape, a primary obstacle on the path to birth justice has been that the abuses that women face during childbirth have been deemed "personal," and therefore have gone unreported and unaddressed. By systematically documenting these cases,

NAPW hopes to better understand the nature scope of the problem and identify the specific human rights violated, giving activists and advocates information they need to articulate and challenge these violations.

Birth Justice and Family Justice

Like birth justice, parenting justice has received relatively little attention in the overall reproductive justice agenda. The issues of birth justice and parenting justice are particularly intertwined, as child protective interventions have been used as threats to force compliance with medical advice—and even compel medical procedures—during pregnancy and birth. When child protective services get involved with birth, families are subjected to an invasive system in which they have virtually no procedural rights, and anything—most notably poverty and even immigration status—can be used against them. For example, Cirila Baltazar Cruz, a woman from Oaxaca, Mexico and working in Mississippi, went to deliver her daughter Rubí at the Singing River Hospital in Pascagoula, only to have her taken away by child protective services because Mrs. Cruz speaks only Chatino, an indigenous language. According to the judge, the fact that Mrs. Cruz speaks no English and very little Spanish places her daughter at risk in an emergency situation. No evidence has suggested that Rubí would be neglected or abused by her mother.

Conclusion

We thank the Bynkershoek Institute for organizing this conversation, providing us with the opportunity to share our vision of birth justice with this esteemed group of legal scholars and advocates for improvement of maternity care. We look forward to a greater understanding of birth justice and what can be achieved when it is fully incorporated into reproductive justice.